

UNCLASSIFIED

**NAVY HEALTH CARE REVIEW
COMMITTEE**

**VOLUME I
FINAL REPORT**

JANUARY 1976

VOLUME I OF IV VOLUMES

UNCLASSIFIED

TABLE OF CONTENTS

VOLUME I		PAGE
TABLE OF CONTENTS		i
Executive Summaries		E-i
Section I	Introduction: Background and Methodology	I-2
Section II	Health Care Demand.	I-12
Sections		
A.	NHCRC Review of NHCS Beneficiaries, their Entitlements and the Workload Demand on the Future.	I-13
B.	NHCRC Review of Navy Health Care Support Requirements.	I-32
C.	NHCRC Review of Navy Medical Contingency Requirements (MEDCON) Study	I-43
D.	Marine Corps Health Care System Requirements.	I-47
E.	NHCRC Summary of Fleet Health Care Support Requirements.	I-59
F.	NHCRC Review of Medical Facilities to Support Amphibious Task Force/Landing Force (ATF/LF) Combat Operations.	I-67
Section III	Health Care System Influences and Relationships	I-68
Sections		
A.	NHCRC Review of Civilian Influences and Relationships Upon the NHCS	I-69
B.	NHCRC Review of Non-Navy Federal Influences and Relationships Upon the NHCS	I-87
Section IV	Navy Health Care Organization	I-102

	PAGE
Sections	
A. Overview of the Organization of the Navy Health Care System	I-103
B. NHCRC Review of Organization and Status of Naval Medical and Dental Regionalization Program.	I-115
Section V Health Care Support Functions	I-120
Sections	
A. Health Care Support Functions: Patient Care	I-121
B. NHCRC Review of Definitions of the Essential Elements of Health Care Support for the Operating Forces	I-135
C. NHCRC Review of Navy Medical Department Personnel Augmentation to the Operational Forces	I-140
D. NHCRC Review of Medical Department Education and Training	I-142
E. NHCRC Review of Medical Research and Development.	I-163
Section VI Health Care Resources	I-181
Sections	
A. NHCRC Review of Military Manpower Requirements	I-182
B. NHCRC Review of Personnel Management of the Health Care Community.	I-197
C. NHCRC Review of Navy Medical Department Fixed Facilities	I-252
D. NHCRC Review of Navy Health Care Facilities Modernization Program	I-257
Section VII Navy Health Care Program Planning.	I-261
Section VIII Summary of Principal Findings and Conclusions	I-274

TABLE OF CONTENTS

VOLUME II	PAGE
TABLE OF CONTENTS.	i
Appendix A	
OP-00 Memo Ser 289-75 of 6 June 1975, Subj: Review and Definition of Future Navy Health Care System.	II-1
Appendix B	
Listing of Officers and Fleet Commands Contacted by the NHCRC Working Group	II-5
Appendix C	
Examples of Professional Proficiencies and Skill Competencies	II-8
Naval Medical Officer (NMO) Naval Dental Officer (NDO) Naval Medical Service Corps Officer (NMSCO) Naval Nurse Officer (NNO) Naval Enlisted Hospital Corpsman (HM) Naval Dental Technician (NDT)	
Appendix D	
Executive Summary - Rationale for Requirements Determinations	II-14
MEDCON Study Final Report, Draft Revision.	II-21
Time-Phased Navy Requirements Tables located in Volume III (Classified SECRET)	II-61
Appendix E	
AMA Legislative Department, Summary of the National Health Planning and Resources Development Act of 1974.	II-62
Appendix F	
Naval Regional Dental Facilities	IV-68
Naval Regional Medical Facilities.	IV-71

Appendix G

SECNAVINST 6440.1A, BUMED-52, 2 September 1975	II-78
---	-------

Appendix H

NHCRC Memo 10 of 11 August 1975, Subj: Descriptive Comprehensive Review of Medical Department Education and Training; request for . . .	II-94
Index of Comprehensive Descriptive Review of Education and Training; By General Subject Category, Tab, and Content	II-99
Special Assistant for Medical Department Education and Training	II-102
BUMEDINST 5450.47G, 0011	II-103
U.S. Navy Medical Department Education and Training: 1975, <u>An Overview</u>	II-107
FY 1977 NAVCOMPT Submit.	II-133

Appendix I

Medical Department Officer Billet Requirements	II-141
Medical Department Enlisted Billet Requirements	II-142

Appendix J

Navy Regional Medical Center and Navy Hospital Facility Information	II-144
Bed Capacity and Operating Beds BUMED Commanded Dispensaries and Branch Dispensaries	II-147
Initial Acquisition, BUMED Investment in Medical Centers and Hospitals (as of 30 June 74)	II-151
Comparison of Nonmenclature and Definitions Applicable Old and New DOD Instructions	II-153

PAGE

Appendix K

Fiscal Year 1974 Medical Military Construction (MILCON) Program	II-159
--	--------

Appendix L

Medical Support (OP-04) TOA Navy Displayed by Program Element.	II-170
Navy Medical Support Program Major Inter-relationships	II-173
Program Change Decision, PCR No. X-5-025 Submit.	II-178

Appendix M

Glossary of Abbreviations	II-210
-------------------------------------	--------

TABLE OF CONTENTS

	VOLUME III (SECRET)	PAGE
TABLE OF CONTENTS		i
Section I Marine Corps Health Care System Requirements (U) (SECRET)		III-2
Section II NHCRC of Medical Facilities to Support Amphibious Task Force/Landing Force (ATF/LF) Combat Operations (U) (SECRET)		III-33
Appendix A		
Rationale for Requirements Determinations (UNCLAS)		III-43
Time-Phased Navy Requirements Tables (SECRET) . . .		III-51
Appendix B		
Amphibious Fleet Notional Ship Medical Capabilities (U) (SECRET)		III-54
Amphibious Task Force Capabilities to Perform Medical Support Mission (CINCLANTFLT) (UNCLAS) . . .		III-55
CNO ltr ser 96/920 of 1 May 1974; Subj: Fleet and Marine Corps Medical/Dental Support Ships (UNCLAS)		III-61
Recommendations Expanded (U) (SECRET)		III-62
Appendix C		
FMFLANT Statement (UNCLAS)		III-68
Appendix D		
Glossary of Abbreviations		III-72

TABLE OF CONTENTS

VOLUME IV		PAGE
TABLE OF CONTENTS		i
Introduction.		IV-1
Section I	NHCRC Fleet Questionnaire	IV-2
Section II	CINCLANTFLT Response to NHCRC Questionnaire	IV-10
Section III	CINCPACFLT Response to NHCRC Questionnaire	IV-102
Appendix A	Glossary of Abbreviations	IV-356

EXECUTIVE SUMMARIES

Introduction: Background and Methodology

NHCRC Review of NHCS Beneficiaries, Their Entitlements and the Workload Demand in the Future

NHCRC Review of Navy Health Care Support Requirements

NHCRC Review of Navy Medical Contingency Requirements (MEDCON) Study

NHCRC Review of Marine Corps Health Care System Requirements

NHCRC Summary of Fleet Health Care Support Requirements

NHCRC Review of Medical Facilities to Support Amphibious Task Force/Landing Force (ATF/LF) Combat Operations

NHCRC Review of Civilian Influences and Relationships Upon the NHCS

NHCRC Review of Non-Navy Federal Influences and Relationships

NHCRC Review of the Organization of the Navy Health Care System

NHCRC Review of Organization and Status of Naval Medical and Dental Regionalization Program

Health Care Support Functions: Patient Care

NHCRC Review of Definitions of the Essential Elements of Health Care Support for the Operating Forces

NHCRC Review of Navy Medical Department Personnel Augmentation to the Operational Forces

NHCRC Review of Medical Department Education and Training

NHCRC Review of Medical R&D in the Navy Health Care System

NHCRC Review of Military Manpower Requirements

EXECUTIVE SUMMARIES (Continued)

NHCRC Review of Personnel Management of the Navy Health
Care Community

NHCRC Review of Navy Medical Department Fixed Facilities

NHCRC Review of Navy Health Care Facilities Modernization
Program

NHCRC Review of Navy Health Care Program Planning

EXECUTIVE SUMMARY

INTRODUCTION: BACKGROUND AND METHODOLOGY

I. BACKGROUND:

A. The Chief of Naval Operations in a memorandum of 6 June 1975 designated a select committee to review the Navy Health Care System and define a Navy Health Care System for the future. (Appendix A contains a copy of OP-00 Memo 289-75.) This Committee was entitled the Navy Health Care Review Committee (NHCRC.) The Committee was tasked to accomplish three broad objectives:

1. Prepare a comprehensive description of the Navy Health Care Program as it exists today;
2. Develop broad health care objectives for the future;
3. Devise a plan for achievement of those objectives.

B. The Committee organization followed the pattern of a CNO study. The NHCRC Steering Group, chaired by the Vice Chief of Naval Operations (VCNO), was comprised of key policy officials most concerned with the Navy Health Care Program. The NHCRC Working Group included a balanced membership of medical department officers and non-medical department officers of the Navy and Marine Corps in order to provide a cross section of Navy viewpoints concerning Navy health care.

II. APPROACH:

The overall review plan and time-phasing for the NHCRC effort was constructed to permit accomplishment within the assigned six month time period. The relatively short time allocated for the review necessitated a structured approach to the achievement of the three broad objectives. Thus the general approach taken in the review was to identify problems and current initiatives in the Navy Health Care System in order to develop broad objectives for the Navy Health Care System of the future.

III. ASSUMPTIONS AND BASIC PREMISES:

A. Three assumptions were adopted in the formulation of the review:

1. NHCRC statements will take into consideration OMB/HEW/DOD Military Health Care Study findings and constraints;

2. Navy MEDCON Study results are the authoritative statement of Navy medical contingency requirements;

3. Legislation can be changed.

B. Basic premises were also adopted in order to recognize certain doctrinal and fact of life considerations. These were:

1. External influences - which must be recognized - impose additional health care demands upon the Military (Navy) Health Care System by higher authority (i.e., Congress, DOD) through statute, policy and case law;

2. The Navy Health Care System includes health care provided by civilian sources (i.e., CHAMPUS and active duty outservice care programs);

3. Navy Regulations and SECNAVINST 5400.13 set forth responsibilities for Navy health care. These responsibilities are understood to be that the Chief of Naval Operations (CNO) and the Commandant of the Marine Corps (CMC) are to plan and provide health care for personnel of their respective services (and their dependents); the Chief, Bureau of Medicine and Surgery must be responsive in meeting the health care needs (requirements) of the Navy and Marine Corps as determined by the CNO and CMC.

IV. METHODOLOGY:

A. The description of the current Navy Health Care System was structured by descriptive categories from a management perspective. The orientation of the review and resulting description has been to highlight problems and ongoing initiatives in the current system in order to provide a basis for development of future objectives. The review was conducted by means of briefings, discussions and visits in order to obtain information and views of various Navy Department and fleet offices.

B. The broad guidance objectives for the Navy Health Care System of the future have been constructed as Navy Health Care Objective Statements addressed to CHBUMED who then determines how the health care requirements and objectives are to be met. The several Objective Statements

contained in the report constitute a redirection of the Navy Health Care System with reemphasis of priorities for health care support of the operating forces and active duty personnel of the Navy and Marine Corps.

C. The "architectural plan" for achievement of Navy Health Care Objectives has been developed as a time-phased plan of action and milestones (POA&M) for each of the Objective Statements and major recommendations. The "architectural plans" identify major action offices and provide a narrative action plan in addition to a time-phased, graphic display.

D. Implementation of NHCRC Objective Statements and recommendations is intended to be on a continuing, monitorable basis. Therefore, the NHCRC recommends initial inclusion of these items in the CNO Program Analysis Memoranda (CPAM) process for FY 1978. Annual monitoring and evaluation of Navy Health Care Objectives will then occur in subsequent CPAM cycles. Follow-on direction or redirection could then be appropriately issued in the annual CNO Program Planning Guidance document (CPPG).

V. EXCLUSIONS:

All aspects of the Navy health care effort were not completely reviewed by the Committee. The review was oriented toward setting future objectives for the Navy Health Care System. The prime continuing effort was to generate policy guidance by which the future Navy Health Care System could evolve. Certain subject areas have been exposed to in-depth review in prior studies and analyses, particularly the areas of resource and personnel utilization.

VI. SUMMARY:

The NHCRC has reviewed the current Navy Health Care System, identified significant problems and ongoing initiatives and formulated a series of Navy Health Care Objective Statements and Recommendations. The primary thrust and intent of those statements and recommendations is to reemphasize and improve health care support to active duty personnel and the operating forces of the Navy and Marine Corps.

II-A

EXECUTIVE SUMMARY: NHCRC REVIEW OF NHCS BENEFICIARIES, THEIR ENTITLEMENTS-AND THE WORKLOAD DEMAND IN THE FUTURE

I. Purpose

This review investigated the basis of the various categories of beneficiaries and their entitlements. It gathered workload and population data and generated a forecast of the future workload demand of health care services.

II. Findings

USC Title 10 contains the listing of Health Care System beneficiaries with their entitled services. Population and workload data are incomplete and not centrally controlled. Various forecasting models and techniques have been devised, but without conclusive results.

III. Conclusions

The population and workload data that is captured, but not all collected, is sufficient to support fiscal year planning and budgeting. The lack of a central population data collection point hinders the effective utilization of the existing data. Until exact per capita budgeting is supported at the Department of Defense level, a more centralized data collection and analysis effort should produce information of sufficient reliability and depth to support workload forecasting. The Composite Workload Unit (CWU) is not a valid measure of total medical facility workload. It considers only non-weighted direct patient care. There appears to be a continuing decline in the use of less costly uniformed health service facilities.

IV. Recommendations

A. CNO/CMC establish and support a population and workload collection system centralized at BUMED.

B. CNO/CMC designate BUMED as the single source of Navy and Marine Corps health care population data for input to any tri-service or DOD population effort.

C. CNO propose to DOD that a more meaningful and effective measure of medical workload be devised.

II-B

EXECUTIVE SUMMARY: NHCRC REVIEW OF NAVY HEALTH CARE SUPPORT REQUIREMENTS

I. Purpose

This review establishes the essential definitions by which individual elements of the Navy's Health Care System can be categorized and evaluated.

II. Findings

The NHCRC did not find a published definition of "Health Care Support Requirements." The committee has generally defined this term and further identified the differences between traditional civilian health care support requirements and the Navy Health Care Support Requirements.

III. Conclusions

Definition of these basic Navy Health Care Support Requirements permits the parallel categorization of other elements of the NHCS. Examples of broad skill categories of medical department personnel necessary to support the defined requirements were developed and are presented in Appendix C.

IV. Recommendation

Surgeon General adopt the definition of "Navy Health Care Support Requirements" to the greatest extent possible as the basis upon which to evaluate and appropriately balance the orientations, skills, and capabilities of Navy Medical Department personnel.

II-C

EXECUTIVE SUMMARY: NHCRC REVIEW OF NAVY MEDICAL CONTINGENCY REQUIREMENTS (MEDCON) STUDY

I. Purpose

The NHCRC reviewed the methodology by which the Navy determines its medical contingency resource requirements, with specific emphasis on examination of the ADP model, Medical Contingency Requirements (MEDCON) Study.

II. Discussion

The purpose of the MEDCON Study was "to develop an appropriate data base and an ADP model which would be sensitive to given Navy scenarios and contingency plans and which could generate a documented, quantified statement of medical contingency requirements."^{1/} The model employs the same basic data as that which is used in manual computations, related to the USCINCEUR OPLAN 4102 (Case 4/1), but modified by SEAMIX analyses. The output of data reflects facilities and manpower resources required to support any chosen contingency operation, based upon casualty estimates and any variety of evacuation policies.

III. Conclusion

The MEDCON Model is an efficient manipulatable ADP planning process for determining medical personnel and facilities resources required to support operational contingencies.

IV. Recommendation

That CHBUMED continue efforts to expand the MEDCON Model to a follow-on MEDCON-II Study which will develop a conceptually updated and more analytically sophisticated approach to generating medical contingency requirements.

^{1/} Abstracts of Past Studies on Health Care Systems, (MEDCON) DOT Systems Inc., Vienna, Va., 16 Sep 1975 (ONR Contract N00014-74-C-0281).

II-D .

EXECUTIVE SUMMARY: NHCRC REVIEW OF MARINE CORPS HEALTH CARE SYSTEM REQUIREMENTS

I. Purpose

To define the health care requirements necessary to support Fleet Marine Force Task organizations operating in varying degrees of conflict intensity from either ashore or seabased service support posture.

II. Discussion

A. The significant features and functions of the present system were defined and analyzed, deficiencies identified, and where possible, alternative solutions were proposed to adequately satisfy foreseeable FMF health care requirements.

B. The major areas addressed are: Medical and Dental support requirements, control and communications, organization for landing force medical service, medical and dental supply, material, and equipment and facilities.

III. Conclusions

A. The Health Care System available to support projected FMF operational requirements is inadequate in terms of the trained personnel (organic or in regional centers) and responsive facilities (afloat or ashore) necessary to deal with any form of contingency situation in which FMF units are expected to sustain casualties.

B. The objectives and orientation of the present Health Care System do not reflect the proper degree of sensitivity to the concept of priority service to operational units of the FMF in the form and degree that would make the system mission oriented.

IV. Recommendations

A. The FMF health care support requirements be met or at least be given the same priority and consideration that Navy requirements receive.

B. That CHBUMED initiate and maintain frequent and prescribed contact with CMC in order to ensure that both quantitative and qualitative health care support is provided to the FMF based upon both peacetime and combat requirements.

II-E

EXECUTIVE SUMMARY: NHCRC SUMMARY OF FLEET HEALTH CARE SUPPORT REQUIREMENTS

I. Purpose

To identify fleet operation health care requirements and place them in their proper perspective in the Navy Health Care System.

II. Discussion

A. A Joint Workshop with representatives of Fleet CINCs and NHCRC members was held during the period 3-7 November 1975. Fleet health care requirements were addressed through use of a problem identification and statement development technique.

B. Problem areas relating to Fleet health care requirements were revealed: from Fleet responses to a NHCRC questionnaire, during the workshop by draft problem statements, through presentations by Fleet representatives, and from workshop discussions.

C. Each of the problem areas identified during the workshop was discussed.

III. Conclusions

A. Problem areas exist in responsiveness of the Navy Health Care System to the operating forces.

B. Resolution of the problems will stem from increased emphasis and attention to these requirements.

IV. Recommendation

That highest possible priority be given to implementing Navy Health Care Objective Statements #1 and #4.

II-F

EXECUTIVE SUMMARY: NHCRC REVIEW OF MEDICAL FACILITIES TO SUPPORT AMPHIBIOUS TASK FORCE/ LANDING FORCE (ATF/LF) COMBAT OPER- ATIONS

I. Purpose

The NHCRC reviewed the health care facilities requirements and capabilities to support an amphibious landing. Shortfalls were identified and a combination of recommendations developed.

II. Discussion

Medical facilities required to be provided ashore and afloat in support of an amphibious landing were examined in detail, capabilities described, and shortfalls/deficiencies revealed. Sources of support analyzed included Amphibious Task Force ships, other alternatives to hospital ships, medical facilities organic to the USMC Landing Force, and advance base functional components. Aeromedical evacuation was briefly discussed.

III. Conclusion and Recommendations

The classified conclusion and recommendations are contained in Volume III.

III-A

EXECUTIVE SUMMARY: NHCRC REVIEW OF CIVILIAN INFLUENCES AND RELATIONSHIPS UPON THE NHCS

I. Purpose

The nature, extent and scope of civilian influences upon the NHCS was reviewed.

II. Findings

A. The influences of civilian health and health related organizations, bodies, and agencies are inseparable from the CNO/CMC responsibility to plan and provide health care.

B. Figure A-1 is a conceptual model of relationships.

III. Conclusions

A. Navy advantages of civilian influences and relationships:

1. Surveillance and monitoring
2. Documented public accountability
3. Assurance of competency and proficiency
4. Protection against litigation
5. Interchange of communications and education
6. Naval prestige enhancement
7. Participation in shared national public interests
8. Accreditation
9. Representation on behalf of Navy interests
10. Comparison of indices of health status
11. Maintenance of standards
12. Sharing of advances in technology

B. Navy disadvantages of civilian influences and relationships:

1. Constraints in exercising priorities
2. Constraints in limiting resource allocation

IV. Recommendation

SGN/CHBUMED should improve recognized medical department management controls by formulating explicit criteria and guidelines whereby NHCS/civilian interrelationships, objectives, activities, and expected benefits are clearly delineated.

III-B

EXECUTIVE SUMMARY: NHCRC REVIEW OF NON-NAVY FEDERAL INFLUENCES AND RELATIONSHIPS

I. Purpose

The Committee reviewed the nature and impact of external Federal influences and relationships upon the NHCS.

II. Discussion

There are extensive and complex formal and informal lines of Federal authority, guidance, policy, and expectations which impact upon both the management and provision of Navy health care support services.

III. Conclusions

Influences external to Navy will continue to impact heavily upon the character, quality, cost, and line control of existing Navy health care support. Evident trends reflect increasing centralized management and extensive consolidations of tri-service health services. NHI legislation uncertainties along with absence of valid planning decisions make accurate prediction of future Navy health care support difficult.

IV. Recommendation

All pertinent information relevant to further evolution of centralized management, extensive consolidation, and NHI legislation should be assessed in depth. Forthcoming suggested decisions and positions should assure the provision of adequate and appropriate health care support for at least all AcDu personnel.

IV-A

EXECUTIVE SUMMARY: NHCRC REVIEW OF THE ORGANIZATION OF THE NAVY HEALTH CARE SYSTEM

I. Introduction

The purpose of this review is to briefly describe the relationship of BUMED/SGN to those activities and elements of the Navy Medical Department which are described as BUMED managed or non-BUMED managed; and, the methods by which the Surgeon General carries out the missions of: (1) the Navy Medical Department and, (2) BUMED.

II. Discussion

The discussion considers:

- A. Departmental Command Relationships
- B. Field level command structure
- C. CHBUMED command responsibilities
- D. SGN Technical Advisor responsibilities
- E. The Navy health care delivery organization
- F. Implications of organization on health care delivery and health care resources.

III. Conclusions

A. The organizational structure of the Navy Medical Department is at variance with the ideal functional organization for the Navy Health Care System.

B. The organizational variance is a necessary fact of life in a health care system which is a subordinate element of the Navy.

C. Close SGN coordination of the non-BUMED managed segment of the Navy Medical Department is essential to ensure effective and efficient functioning of the entire Navy Health Care System.

D. Modification of the present resource programming and accounting systems will be required to achieve complete identification and management of the total Navy health care resource commitment.

IV. Recommendations

A. That the Surgeon General of the Navy give appropriate emphasis to technical advice to and communication with the non-BUMED managed elements of the Navy Medical Department in order to optimize their essential contribution to the Navy Health Care System.

B. That OP-090 and BUMED explore ways to improve Navy health care resource programming and accounting.

IV-B

EXECUTIVE SUMMARY: NHCRC REVIEW OF ORGANIZATION AND STATUS OF NAVAL MEDICAL AND DENTAL REGIONALIZATION PROGRAM

I. Purpose

To review the Navy's progress toward regionalization of the Medical Department.

II. Discussion

Regionalization commenced for Navy medicine in 1972 and for Navy dentistry in 1974 and both will be essentially completed by the end of 1975. Regionalization brought about the transfer of medical facilities from local area line commanders to the CHBUMED chain of command.

CHBUMED has:

- started formal assessment, analysis, and evaluation of regionalization progress and outcomes.
- directed correction of maldistribution of personnel resources.
- clarified "top priority attention" in support of the operational forces.

III. Conclusions

● Associated problems with the shift in chain of command responsibility due to regionalization are:

- New constraints
- Personnel distribution
- Diminished responsiveness

● Regionalization appears in general to be progressing satisfactorily.

● The observed initiatives must be sustained.

EXECUTIVE SUMMARY: HEALTH CARE SUPPORT FUNCTIONS:
PATIENT CARE

I. Introduction

This section briefly outlines a summary of many classifications developed throughout this review of the Navy Health Care System. Furthermore, it provides a discussion of two additional subjects; an arbitrary classification of the complexity of the range of patient care services and a functional explanation of the continuum of patient care. Summarization of the immediately relevant classifications developed during this review provides a useful orientation of dynamic patient care relationships in the Navy Health Care System.

II. Discussion

A. Primary, secondary, and tertiary care comprise artificial divisions of levels of complexity of care to indicate ranges of health care. Within the Navy all tertiary care centers function throughout the entire spectrum of health care complexity. Thus regional centers produce weighted workload outputs consistent with each level of complexity and no center performs tertiary care to the exclusion of secondary and primary care.

B: The Continuum of Patient Care. The several divisions of health care services require different professional skills, equipment and facilities support. However, none of the three levels of care can stand alone. Only where the three levels are available and coordinated in a continuum of care does the active duty population have the comprehensive range of personal health care services to which they are entitled by law.

III. Conclusions

A. The patient care functions inherent in the Navy Health Care System exist in a complex, interrelated array of varying care capabilities. This array can conceptually be viewed as a continuum of health care services.

B. The medical facilities (afloat and ashore) of the Navy and Marine Corps each contribute to the continuum of care and represent a level of capability within the health care system.

C. The Navy organization and resource allocation structure is superimposed upon this continuum of care. An erroneous tendency therefore exists to view the various echelons of Navy health care facilities as separate and distinct organizations. The important distinction to be made is that the various echelons of facilities, while separately administered, must function as essential co-contributors to the overall Navy Health Care System.

V-B

EXECUTIVE SUMMARY: NHCRC REVIEW OF DEFINITIONS OF THE ESSENTIAL ELEMENTS OF HEALTH CARE SUPPORT FOR THE OPERATING FORCES

I. Purpose

The NHCRC identified and defined the major categories of health care required to support the operating forces.

II. Discussion

The NHCRC, in reviewing existing and proposed doctrinal publications dealing with health care services and interviewing various medical authorities, identified and provided broad definitions for four major categories of Navy health care. The categories identified were: Illness, Injury and Wound Care; Preventive Medicine; Health Care Planning; and, Health Care Logistics.

III. Conclusions

A. A conflict was found to exist in the definitions of the elements of health care contained in various doctrinal publications. Proper use of the four categories of health care identified by the NHCRC will clear up much of the confusion this conflict creates.

B. The four health care categories provided a useful frame of reference for conduct of the Navy Health Care Review.

IV. Recommendation

BUMED use the definitions of health care categories identified by the NHCRC in order to provide a commonly understood frame of reference by which to facilitate discussion and communication between the medical department and the forces to which it provides health care support.

V-C

EXECUTIVE SUMMARY: NHCRC REVIEW OF NAVY MEDICAL DEPARTMENT PERSONNEL AUGMENTATION TO THE OPERATIONAL FORCES

I. Purpose

The doctrinal method for providing augmentation of Medical Department personnel from Bureau of Medicine and Surgery commanded activities to units of the operational forces, including Fleet Marine Forces, was reviewed.

II. Discussion

Formally described Medical Department personnel augmentation is available, both in the form of team augmentation to the fleets and FMF (as in Surgical Teams), and in the form of individual augmentation to II and III Marine Amphibious Forces (MAF) in order to immediately build II and III MAF up to established Table of Organization (T/O) strength level. All designated augmentation personnel are name-identified and on sufficient alert to satisfy quick response.

III. Conclusion

The means for rapid personnel augmentation exist both regarding team support to the fleets and FMF, and individual augmentation; however, SECNAVINST 6440.1A, directs that FMF request immediate personnel support in a manner not consistent with the established chain-of-command, in that it excludes the Fleet CINCs, CNO, and CMC.

IV. Recommendation

CHBUMED, assisted by appropriate offices within HQMC, initiate action to revise SECNAVINST 6440.1A which will cause adherence to established chain-of-command procedures when FMF major commands request medical personnel to fill II and III MAF T/O billets.

EXECUTIVE SUMMARY: NHCRC REVIEW OF MEDICAL DEPARTMENT
EDUCATION AND TRAINING

I. Purpose

Review of Medical Department education and training reflects selected instructive and informational data and focuses on substantive problems and initiatives. This review provides a basis for the development of a proposed Navy Health Care Objective Statement.

II. Contents

- A. Review methodology
- B. Discussion of Education and Training in terms of:
 - 1. General
 - 2. Organization
 - 3. Purpose
 - 4. Programs
 - 5. Accountability
 - 6. Requirements
 - 7. Resources
 - 8. Programs in support of operational forces.
- C. Problems/Initiatives/Findings
- D. Conclusion
- E. Summarization

III. Conclusion

Medical Department education and training efforts must strive within approved resources to ensure that all naval health care personnel are trained adequately with an appropriate balance of priorities and emphasis upon all of the interdependent skills of:

- A. General naval (USN) skills
- B. Naval health care support equivalent (NHE) skills
- C. Civilian health care support equivalent (CHE) skills

V-E

EXECUTIVE SUMMARY: NHCRC REVIEW OF MEDICAL R&D IN THE NAVY
HEALTH CARE SYSTEM

I. Purpose:

The Medical R&D program was reviewed to provide an understanding of its organization, structure, and functions within the Navy and its Health Care System.

II. Discussion:

Organizational and interactive medical R&D managerial relationships are complex but do not defy understanding. Managerial controls and reporting requirements are extensive, and the primary mission directed efforts do contribute to the broader objectives of the Navy.

III. Conclusion:

As a micro-element within a large system, awareness as to the R&D interface in contributing to Navy objectives is easily diminished.

IV. Recommendation:

ONR, OPNAV, NAVMAT, and CHBUMED ensure the approved mechanisms of timely communication include medical R&D program participation.

VI-A

EXECUTIVE SUMMARY: NHCRC REVIEW OF MILITARY MANPOWER REQUIREMENTS

I. Purpose

The Navy military manpower system was reviewed to provide an understanding of its function and to identify those problem areas and current initiatives that were related to the Navy Health Care System.

II. Discussion

This section addresses billets in the terms of those billet requirements that are authorized and funded by CNO. These billets are differentiated from personnel or "bodies."

III. Conclusion

The problems identified in this section are in the process of being reviewed or have already been corrected to some degree. Those initiatives identified are considered worthwhile.

IV. Recommendation

Those initiatives identified should be continued. Efforts to resolve existing problems should be continued. The problem concerning the Medical Department billet/body mismatch should be monitored periodically by CNO/CNP to ensure that operational fleet units receive priority manning.

VI-B

EXECUTIVE SUMMARY: NHCRC REVIEW OF PERSONNEL MANAGEMENT OF THE NAVY HEALTH CARE COMMUNITY

I. Purpose

The purpose is to set forth the findings of the NHCRC review of a series of briefs given by BUPERS, BUMED and CNRC in the area of personnel resource management as background information for the health care review process.

II. Dicussion

Numerous personnel management functions were covered in the briefs. The body of the review is divided into the following descriptive areas:

- Officer Personnel Strength Planning
- Medical Department Officer Assignments
- Medical Corps Management
- Dental Department Personnel Management
- Medical Service Corps Management
- Nurse Corps Management
- Hospital Corps Management

These management reviews are not intended to be exhaustive but only to investigate those aspects of Medical Department personnel resources management that highlight problem areas/initiatives or that are considered as necessary background data.

III. Conclusions

A. Medical/Dental Corps "grade creep" and promotion rates will have to be lived with at least for the short range.

B. SHOROCS and SHORSTAMPS will be prime vehicle for developing Hospital Corps staffing criteria and standards.

C. Current BUMED/BUPERS initiatives should lead to resolution of existing management problems and manning imbalances.

IV. Recommendations

A. BUMED/BUPERS planners should develop an accurate

short range (24 months) Medical/Dental Corps promotion projection capability.

B. Medical Corps direct accessions should be procured against quotes in the highest grade to be held during the fiscal year or next six months, whichever is longest.

C. Increased Hospital Corps training for contingency demands should be established.

D. Current management initiatives should be continued.

NOTE: These recommendations have been incorporated into NHCRC Objective Statement #3.

VI-C

EXECUTIVE SUMMARY: NHCRC REVIEW OF NAVY MEDICAL DEPARTMENT FIXED FACILITIES

I. Purpose

To provide data on fixed medical department facilities regarding beds, areas, and plant/equipment valuation and to discuss the newly issued DOD Instruction 6015.1 (13 June 1975).

II. Discussion

Appendix J provides tabular accounting data by:

Name of Facility	Area Sq. Ft.
Normal Bed Capacity	Land Acquisition Cost
Expanded Bed Capacity	(Initial)
Authorized Operating Beds	Building and Improvements
NAVFAC Listed Beds	Cost (Initial)
	Equipment Cost (Initial)

The differentiating elements of new DOD guidance for nomenclature and definitions are portrayed in Appendix J. BUMED and NAVFAC are currently revising their common use nomenclature and definitions to comply with the new guidance in all future tabulations.

VI-D

EXECUTIVE SUMMARY: NHCRC REVIEW OF NAVY HEALTH CARE FACILITIES MODERNIZATION PROGRAM

I. Purpose

To review progress and plans for modernizing or replacing all inadequate fixed medical facilities during the period FY 67-81.

II. Discussion

Of the nearly 13,000 beds in Navy hospitals and medical centers, approximately 40% were in temporary or antiquated buildings constructed prior to and during World War II. Age, structural unsoundness, and unreliable utility systems combined to produce fire and safety hazards for the facility users. In addition, modernization has been necessary in order to meet the growing demand for outpatient care brought about by the recent advances in medicine.

III. Conclusions

Barring reductions in requested funds, all major hospital facilities of temporary construction will be replaced by FY 81. The total replacement/modernization program will cost \$1,142,919,000 (FY 67-81).

VII

EXECUTIVE SUMMARY: NHCRC REVIEW OF NAVY HEALTH CARE PROGRAM PLANNING

I. Purpose

A. This Section addresses and describes Navy health care program planning in the FYDP, CPAM and POM processes, the contents of the "Navy Medical Support Program," program sponsorship and the BUMED role with regard thereto.

II. Findings

A. General interest in military health care on the part of OMB, OSD, and the Congress, has generated increasing requirements for health care support resource data.

B. The Navy Medical Support Program included in CPAM/POM reviews is incomplete and does not in fact represent the total Navy Health Care Program. The FY 77 resource displays only include approximately 75% of the Navy's health care resources.

C. Programming sponsorship arrangements fragment the functional health care program segments under three major sponsors.

D. The BUMED role in the program planning process is not clearly defined leading to less than satisfactory BUMED participation in the CPAM/POM process.

E. CPAM/POM cycle communications between sponsors and BUMED are less than optimal in view of the stringency of assigned deadlines and the multiplicity of BUMED and sponsor actions required.

F. OSD directed FYDP Program 8 restructure requires a reevaluation of the program array which reflects Navy health care resources in FYDP, CPAM and POM documents. Such a review will be essential to the FY 79 POM cycle.

III. Current Initiatives:

A. BUMED creation of a separate program planning and analysis office recognizes past problems in CPAM/POM participation. Result should be increased efficacy in BUMED participation beginning with the FY 78 CPAM/POM cycle.

B. FYDP Program 8 restructure initiated by OSD will provide the documentation for a more complete CPAM/POM review of Navy Health Care Program resources.

IV. Recommendation

OP-090 review Navy Medical Support program planning in the following three areas:

A. Sponsorship assignments for the Navy Health Care Support Program; develop appropriate changes for implementation prior to the FY 79 CPAM/POM cycle.

B. Clear, timely communication lines to facilitate BUMED participation in FY 78 CPAM/POM processes.

C. FYDP Program 8 restructure to ensure compliance with OSD guidance contained in DPPG and PCDs.

SECTION I

Introduction: Background and Methodology

SECTION I

INTRODUCTION: BACKGROUND AND METHODOLOGY

I. Background

A. The Chief of Naval Operations in a memorandum of 6 June 1975 designated a select committee to review the Navy Health Care System and define a Navy Health Care System for the future. (Appendix A contains a copy of OP-00 Memo 289-75). This Committee was entitled the Navy Health Care Review Committee (NHCRC). The committee was tasked to accomplish three broad objectives:

(1) Prepare a comprehensive description of the Navy health care program as it exists today;

(2) Develop broad health care objectives for the future;

(3) Devise a plan for achievement of those objectives.

B. The Committee organization followed the pattern of a CNO Study. The NHCRC Steering Group, chaired by the Vice Chief of Naval Operations (VCNO) was comprised of key policy officials most concerned with the Navy health care program. (Figure I-1). The NHCRC Working Group included a balanced membership of Medical Department officers and non-medical department officers of the Navy and Marine Corps in order to provide a cross section of Navy viewpoints concerning Navy health care. Figure I-2 contains the NHCRC membership information.

NAVY HEALTH CARE REVIEW COMMITTEE STEERING GROUP COMPOSITION

CHAIRMAN VICE CHIEF OF NAVAL OPERATIONS (VCNO)

MEMBERS ASST SECRETARY OF THE NAVY FOR MANPOWER AND
RESERVE AFFAIRS (ASN(M&RA))

DIRECTOR OF NAVY PROGRAM PLANNING (OP-090)

DEPUTY CHIEF OF NAVAL OPERATIONS (MANPOWER) (OP-01)

DEPUTY CHIEF OF NAVAL OPERATIONS (LOGISTICS) (OP-04)

ASSISTANT COMMANDANT OF THE MARINE CORPS (ACMC)

CHIEF, BUREAU OF MEDICINE & SURGERY (CHBUMED)

AMERICAN HOSPITAL ASSOCIATION REPRESENTATIVE

Figure I-1

NAVY HEALTH CARE REVIEW COMMITTEE WORKING GROUP COMPOSITION

<u>MEMBERS</u>	<u>SPONSORING OFFICE</u>	<u>FUNCTION</u>
RADM PAUL KAUFMAN, MC, USN	OP-09H	CHAIRMAN
CDR F.G. ANDERSON, MSC, USN	OP-09H1/OP-96	DIRECTOR
CAPT S. BARCHET, MC, USN	BUMED	MEMBER
CDR R. BACON, USN	BUPERS	"
CDR W. SUTHERLAND, USN	OP-04	"
LCDR D. RAY, USN	OP-090	"
LCDR L.P. METCALF, MSC, USN	OP-04	"
LCDR F. CONNORS, MSC, USN	OP-01	"
MAJ N. LADUCA, USMC	HQMC	"

FIGURE I-2

C. Analytical support for the NHCRC was provided by two full-time health care analysts from the Research Division of the Naval School of Health Care Administration. Additional short term contractual assistance was obtained from DOT Systems, Inc., of Vienna, Va., and Boeing Computer Services, Inc., of Seattle, Washington.

II. Approach

The overall review plan and time-phasing for the NHCRC effort (Figure I-3) was constructed to permit accomplishment within the assigned six month time period. The relatively short time allocated for the review necessitated a structured approach to the achievement of the three broad objectives. Thus the general approach taken in the review was to identify problems and current initiatives in the Navy Health Care System in order to develop broad objectives for the Navy Health Care System of the future.

III. Assumptions and Basic Premises

A. Three assumptions were adopted in the formulation of the review:

(1) NHCRC statements will take into consideration OMB/HEW/DOD Military Health Care Study findings and conclusions;

(2) Navy MEDCON study results are the authoritative statement of Navy medical contingency requirements;

(3) Legislation can be changed.

NAVY HEALTH CARE REVIEW COMMITTEE

TIME PHASING

PHASE	TASKS	JULY 31	AUG 31	SEP 30	OCT 31	NOV 30	DEC 31
I.	COMMITTEE START & PLANNING	<div>SET UP</div> <div>DEVELOP PO&M</div>					
II.	DESCRIBE CURRENT NAVY HEALTH CARE PROGRAM	<div>REVIEW EXISTING STUDIES</div> <div>AND ANALYSIS</div>	<div>REVIEW DEMAND (RQMTS)</div> <div>REVIEW SERVICES PROVIDED</div> <div>REVIEW ORGANIZATION & INTERFACES</div> <div>REVIEW HEALTH CARE RELATIONSHIPS</div> <div>REVIEW RESOURCES CURRENT, PLAN, PROJECTED</div> <div>IDENTIFY, PROBLEMS & INITIATIVES</div>	<div>FORECAST</div> <div>FORECAST</div>			
III.	DEVELOP OBJECTIVES	<div>ESTABLISH FRAMEWORK</div> <div>FOR OBJECTIVES DEVELOPMENT</div>	<div>DEVELOP DEMAND (RQMTS) FACTORS AND CRITERIA</div> <div>DEVELOP PROMULGATION, REVIEW AND EVALUATION SYSTEM</div>	<div>IDENTIFY & DOCUMENT OBJECTIVES AND CONTRIBUTORY GOALS FOR FUTURE</div>			
IV.	CONSTRUCT ARCHITECT- URAL PLAN			<div>DEVELOP PLAN OF ACTION</div> <div>DETERMINE SIGNIFICANT MILESTONES</div> <div>FORECAST RESOURCE RQMTS</div> <div>DETERMINE ORGANIZATION RESPONSIBLE</div>			
V.	REPORTING	<div>STEERING COMMITTEE MEETING</div> <div>SKED FINAL REPORT</div>	X	X	X	X	X
				(DRAFT) (SMOOTH)	PHASE I&II	PHASE III	IV

FIGURE I-3

B. Basic premises were also adopted in order to recognize certain doctrinal and fact of life considerations. These were:

(1) External influences - which must be recognized - impose additional health care demands upon the military (Navy) health care system by higher authority (i.e., Congress, DOD) through statute, policy and case law;

(2) The Navy Health Care System includes health care provided by civilian sources (i.e., CHAMPUS and active duty outservice care programs);

(3) Navy Regulations and SECNAVINST 5400.13 set forth responsibilities for Navy health care. These responsibilities are understood to be that the Chief of Naval Operations (CNO) and the Commandant of the Marine Corps (CMC) are to plan and provide health care for personnel of their respective services (and their dependents); the Chief, Bureau of Medicine and Surgery must be responsive in meeting the health care needs (requirements) of the Navy and Marine Corps as determined by the CNO and CMC.

IV. Methodology

A. The description of the current Navy Health Care System was structured by descriptive categories from a management perspective as shown in Figure I-4. The orientation of the review and resulting description has been to highlight problems and ongoing initiatives in the current system in order to provide a basis for development

NAVY HEALTH CARE REVIEW COMMITTEE
REVIEW OF CURRENT NAVY HEALTH CARE SYSTEM

<u>DEMAND</u> <u>(RQMTS)</u> <u>(1)</u>	<u>SERVICES</u> <u>(2)</u>	<u>RESOURCES</u> <u>(3)</u>	<u>RESOURCE</u> <u>MGMT</u> <u>(4)</u>	<u>ORGANIZATION</u> <u>(5)</u>	<u>RELATIONSHIPS</u> <u>(6)</u>
POPULATION	PATIENT CARE	MANPOWER	PLANNING	<u>MED DEPT</u>	<u>DOD</u>
HEALTH CARE ENTITLEMENTS	OPERATIONAL	FUNDS	PROGRAMMING	BUMED	OSD
PATIENT CARE	TRAINING SUPPORT	FACILITIES	BUDGETING	REGIONS	ARMY
OPERATIONAL SUPPORT	RESEARCH	<u>OUTSERVICE</u>	PROGRAM EXECUTION	OTHER	AF
TRAINING		CHAMPUS		NON-BUMED	<u>CIV HEALTH CARE</u>
<u>CONTINGENCY</u> <u>REQUIREMENT</u>		ACDU CARE		FLEET	ASSOCIATIONS
CASUALTY CARE		OTHER GOV'T		FMF	ACCREDITATION
OPERATIONAL SUPPORT				SHORE	LOCAL COMMUNITY
OTHER					<u>OTHER GOV'T</u>
					OMB/H&W/VA
					CONGRESS
*PROBLEMS INITIATIVES	PROBLEMS INITIATIVES	PROBLEMS INITIATIVES	PROBLEMS INITIATIVES	PROBLEMS INITIATIVES	PROBLEMS INITIATIVES

*DERIVED FROM PREVIOUS STUDIES AND NHCRC EVALUATION.

FIGURE I-4

of future objectives. The review was conducted by means of briefings, discussions and visits in order to obtain information and views of various Navy Department and fleet offices. (Appendix B contains a listing of offices and fleet commands contacted by the NHCRC working group.) Substantial information was obtained by means of a questionnaire addressed to the Commanders in Chief of the Atlantic and Pacific Fleets. The questionnaire and fleet responses thereto are contained in their entirety in Volume IV of the report.

B. The broad guidance objectives for the Navy Health Care System of the future have been constructed as Navy Health Care Objective Statements addressed to CHBUMED who then determines how the health care requirements objectives are to be met. The several Objective Statements contained in the report constitute a redirection of the Navy Health Care System with reemphasis of priorities for health care support of the operating forces and active duty personnel of the Navy and Marine Corps.

C. The "architectural plans" for achievement of Navy Health Care Objectives have been developed as time phased plan of action and milestones (POA&M) for each of the Objective Statements and Major Recommendations. The "architectural plans" identify major action offices and provide a narrative action plan in addition to a time-phased, graphic display.

D. Implementation of NHCRC Objective Statements and Recommendations is intended to be on a continuing, monitorable basis. Therefore, the NHCRC recommends initial inclusion of these items in the CNO Program Analysis Memoranda (CPAM) process for FY 1978. Annual monitoring and evaluation of Navy health care objectives will then occur in subsequent CPAM cycles. Follow-on direction or redirection could then be appropriately issued in the annual CNO Program Planning Guidance document (CPPG).

V. Exclusions

A. All aspects of the Navy health care effort were not completely reviewed by the Committee. The review was oriented toward setting future objectives for the Navy Health Care System. The prime continuing effort was to generate policy guidance by which the future Navy Health Care System could evolve. Certain subject areas have been exposed to indepth review in prior studies and analyses, particularly the areas of resource and personnel utilization.

B. Areas not completely reviewed by the committee include:

(1) The dual role of the Surgeon General of the Navy/Chief, Bureau of Medicine and Surgery in relation to health care policy matters. The title Surgeon General of the Navy appears in law but is not defined in law or policy documents.

(2) Utilization of physicians in senior management functions and command staffs. Current Navy policy is to minimize such assignments in order to optimize use of physician professional skills.

(3) Impacts upon Navy health care resources resulting from significant changes in health care services provided, elimination of beneficiary categories or shifting of patient care workload to outservice sources. Detailed analysis of such impacts have been prepared in numerous prior and ongoing Navy and DOD resource studies.

(4) Potential resource impact of expanding beneficiary entitlements or the variety of services provided in naval medical facilities. Such program expansions would, of necessity, be directed by the Congress or DOD. Resource impacts would be directly dependent upon the specifics of the proposed expansion.

VI. Summary

The NHCRC has reviewed the current Navy Health Care System, identified significant problems and ongoing initiatives and formulated a series of Navy Health Care Objective Statements and Recommendations. The primary thrust and intent of those statements and recommendations is to reemphasize and improve health care support to active duty personnel and the operating forces of the Navy and Marine Corps.

SECTION II

Health Care Demand

- Section A - NHCRC Review of NHCS Beneficiaries, their Entitlements and the Workload Demand on the Future
- Section B - NHCRC Review of Navy Health Care Support Requirements
- Section C - NHCRC Review of Navy Medical Contingency Requirements (MEDCON) Study
- Section D - Marine Corps Health Care System Requirements
- Section E - NHCRC Summary of Fleet Health Care Support Requirements
- Section F - NHCRC Review of Medical Facilities to Support Amphibious Task Force/Landing Force (ATF/LF) Combat Operations

SECTION A

NHCRC REVIEW OF NHCS BENEFICIARIES, THEIR ENTITLEMENTS AND THE WORKLOAD DEMAND IN THE FUTURE

I. Purpose

This review studied the legal definition of the various beneficiary categories and the entitlement of health care services of each category. The sources of population and workload data were investigated and available data was gathered. The data was evaluated and combined into a form to permit forecasting of the workload in the out years. This review provides answers to the questions of how much, of what health care, to whom, and under what conditions. The answers are general in nature but should be meaningful to planners or policy makers.

II. Findings

The purpose of the entitlement authorized by the Medical and Dental sections of Title 10 of the United States Code (USC) "is to create and maintain high morale in the uniformed services by providing an improved and uniform program of medical and dental care for members and certain former members of those services, and for their dependents." Title 10 also defines uniformed services, members, and dependents. Table A-1 lists the beneficiaries of the Navy Health Care System with the applicable sections of the U.S. Code.

TABLE A-1

HEALTH CARE SYSTEM BENEFICIARIES SPECIFIED

BY UNITED STATES CODE

Eligible persons at Naval Medical Facilities include:

1. Members, Uniform Services and Reserve Components,
and Retired members Uniformed Services
 - a. Navy and Marine Corps 10 USC 1074a
 - b. Other Uniformed Services 10 USC 1074b
2. Dependents, Uniformed Services 10 USC 1076
3. Members, foreign military service and their
dependents. NATO, 1949; DOD 6310.5; 22 USC 1750
4. Beneficiaries, other Federal Agencies
 - a. VA 10 USC 1074b
 - b. BEC 5 USC 751
 - c. Department of State 22 USC 1156
5. Other persons
 - a. Former women members--maternity 10 USC 1074b
 - b. ARC 10 USC 2602
 - c. SECNAV Designees--SECNAV Authority 24 USC 14
 - d. Civilian humanitarian 5 USC 22,
10 USC 6011
 - e. U.S. Navy Technicians
OUTCONUS OPNAVINST
5720 series
 - f. Other persons OUTCONUS 24 USC 34, 35
42 USC 1701
 - g. POW 31 USC 649a

Note that for practical purposes the vast majority of beneficiaries have a legal entitlement to health care services as defined in 10 USC 1074/1076. A most important condition of dependent entitlement in uniformed service facilities is the fact that care "may" be provided subject to the availability of space, facilities, and staff capabilities. SECNAVINST 6320.8D establishes the priorities of beneficiaries supported in uniformed facilities and the alternatives when a non-availability determination is made. SECNAVINST 6320.8D amplifies Chapter 55 of Title 10 of the USC.

The general categories of health care are delineated in 10 USC 1077 for beneficiaries other than active duty personnel. These specific uniformed service facility entitlements and limitations are listed in Table A-2 .

Essentially, Title 10 identifies the general "what kind of care" and the categories of "to whom." For effective planning, certain population and workload data is also needed. This data is necessary to provide planners with an answer to "how much" health care is required. Since the basis of the Navy health care support efforts is the number of active duty personnel, Figure A-1 depicts the health care system beneficiary population in terms of ratios to the active duty strength. The figure shows that with a very slightly decreasing size of the active duty population, there is a small but constant rise in the size of the total

TABLE A-2
AUTHORIZED MEDICAL CARE FOR DEPENDENTS
IN FACILITIES OF UNIFORMED SERVICES

Only the following types of health care may be provided to dependents as specified in 10 USC 1076:

1. Hospitalization
2. Outpatient care
3. Drugs
4. Treatment of medical and surgical conditions
5. Treatment of nervous, mental, and chronic conditions
6. Treatment of contagious diseases
7. Physical examinations, including eye examinations, and immunizations
8. Maternity and infant care
9. Diagnostic tests and services, including laboratory and X-ray examinations
10. Emergency dental care worldwide
11. Routine dental care outside the United States and at stations in the United States where adequate civilian facilities are unavailable.
12. Dental care worldwide as a necessary adjunct of medical, surgical, or preventive treatment
13. Ambulance service and home calls when medically necessary
14. Durable equipment, such as wheelchairs, iron lungs, and hospital beds may be provided on a loan basis.

The following types of health care may not be provided under 10 USC 1076:

1. Domiciliary or custodial care
2. Prosthetic devices, hearing aids, orthopedic footwear, and spectacles except that--
 - a. outside the United States and at stations inside the United States where adequate civilian facilities are unavailable, such items may be sold to dependents at cost to the United States, and
 - b. artificial limbs and artificial eyes may be provided.

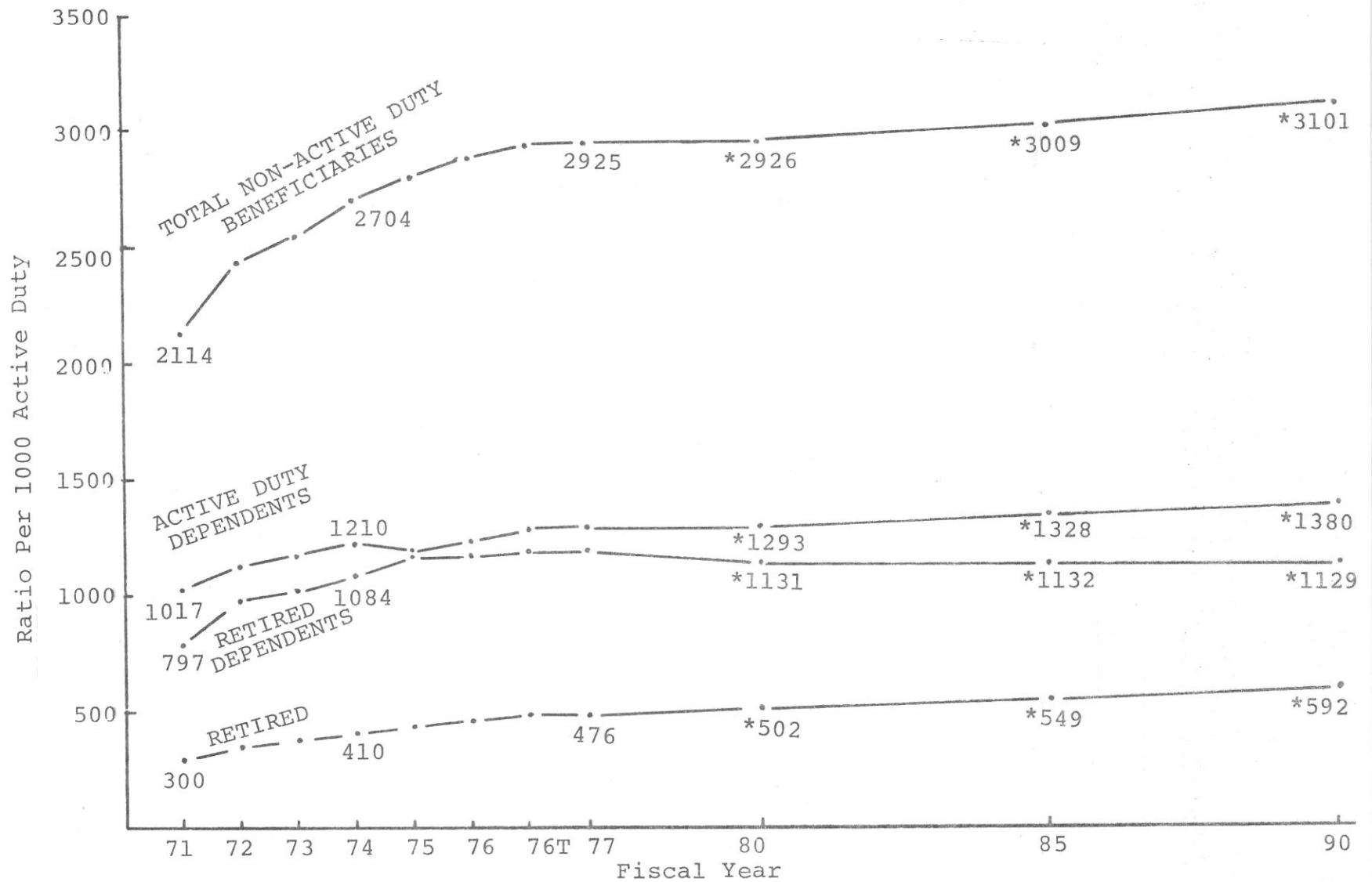


Figure A-1

RATIOS BENEFICIARIES/ACTIVE DUTY

*Calculated from OMB/HEW/OSD Study estimates.

non-active duty segment of beneficiaries, primarily in the retired and dependents of retired sectors. Of key concern to planners is the demographic makeup of the beneficiaries. There are many sources of demographic population data, although there is not a single collection point for the data. Data for the active duty personnel is both accurate and available from NAVPERS and CMC. The data for the dependents of active duty is complete in the CMC files but only the numbers of dependents are maintained by NAVPERS. Demographic data for retired members is maintained by the respective finance centers for the Navy and the Marine Corps but population data for their dependents is scarce. Although little is known about survivors and other beneficiaries, they represent something less than 3% of the potential beneficiary population. For all beneficiary categories we know:

- 84% of the number of beneficiaries accurately identified
- 78% of the location of the beneficiaries
- 50.5% of the age and sex of the beneficiaries

This percentage of known data is less than adequate for precise health care system planning.

The missing information is now estimated by system planners. The best solution to this missing data dilemma is to commence collecting it. The costs of such a collection effort must be less than the value of the anticipated benefits to be derived from the additional data. Figure A-2

Key	Validity/ Quality
1 number	L Low
2 location	M Moderate
3 age	H High
4 sex	

	Active Duty Data	Active Duty Dependent Data	Retired Data	Dependents of Retired Data	Survivors Data	Others	Cost	Resources Required for Collection and Maintenance
Present System Augmented	1 H 2 H 3 H 4 H	1 H 2 M 3 M 4 L	1 H 2 M 3 H 4 H	1 M 2 M 3 L 4 L	1 L 2 L 3 L 4 L	1 L 2 M 3 L 4 L	Low	SMALL collection of existing data files with small amount of manipulation
Sampling Technique	1 H 2 H 3 H 4 H	1 H 2 H 3 M 4 M	1 H 2 M 3 H 4 H	1 M 2 M 3 M 4 M	1 M 2 M 3 L 4 L	1 L 2 M 3 L 4 L	Moderate	LARGE small separate group full time to collect, validate and analyze on a periodic basis
Subset of Enrollment	H	H	H	H	M	M	High/ Very High	VERY LARGE large dedicated group with worldwide repre sentatives oper ating in a new system on a continual basis

FIGURE A-2

depicts the three most promising sources of demographic population data with relative degrees of validity and quality and a general cost estimate of each technique.

Workload data for all Navy medical facilities is collected by BUMED and published quarterly in "Statistics of Navy Medicine." The data is essentially displayed in the format of the factors of the Composite Work Unit (CWU) for individual medical activities and various other categorical summations of these activities. The calculation of the CWU assumes that within each factor, all of the services provided (work performed) are of equal value. The degree of care provided is also not considered in the CWU. For example, intensive and intermediate care is equivalent to the workload associated with comprehensive care of a patient. The measurements are totally patient oriented (patients admitted, patient births, patient bed days, and outpatient visits) rather than a standard measure of work (manday or manhour, or equivalent man work unit). Additionally, work which is not directly related to a patient (R&D, education and training, administration functions) is lost. At best the CWU can only be considered as a relative measure of selected workload elements. To realistically compare facility CWU figures, the facilities must be homogeneous, i.e., almost identical in size, function, and services provided to similar populations. A more realistic and functional measurement

of workload is necessary from the planner's point of view. It must reflect and be applicable to all work performed at a medical facility, not just the direct patient care workload. To be meaningful in the budget cycle, this unit must be identified at the OSD level and be joint service generated and used.

Figure A-3 shows the relative decreases in the CWU for the total Navy in-house facilities along with the general increases in the total beneficiary population. Figure A-4 further supports the observation that a steady decline has existed in the quantity of health care services provided within Navy medical facilities during the last four years. Four causative factors have been identified for this decline. First is the overall decline in service strength of active duty members. Second is the disappearance of the SEASIA combat patient workload from the system. Third is the decrease in patient care capabilities in Naval medical facilities due to a draw-down in Medical Corps numbers and staffing. Fourth is the dramatic increase in the technology of providing health care services creating a greater amount of attention being required per individual patient. This factor is undoubtedly a strong influence on the amount of resources committed per workload unit. Unexplainable, however, is the lack of a concurrent proportional increase in CHAMPUS workload during

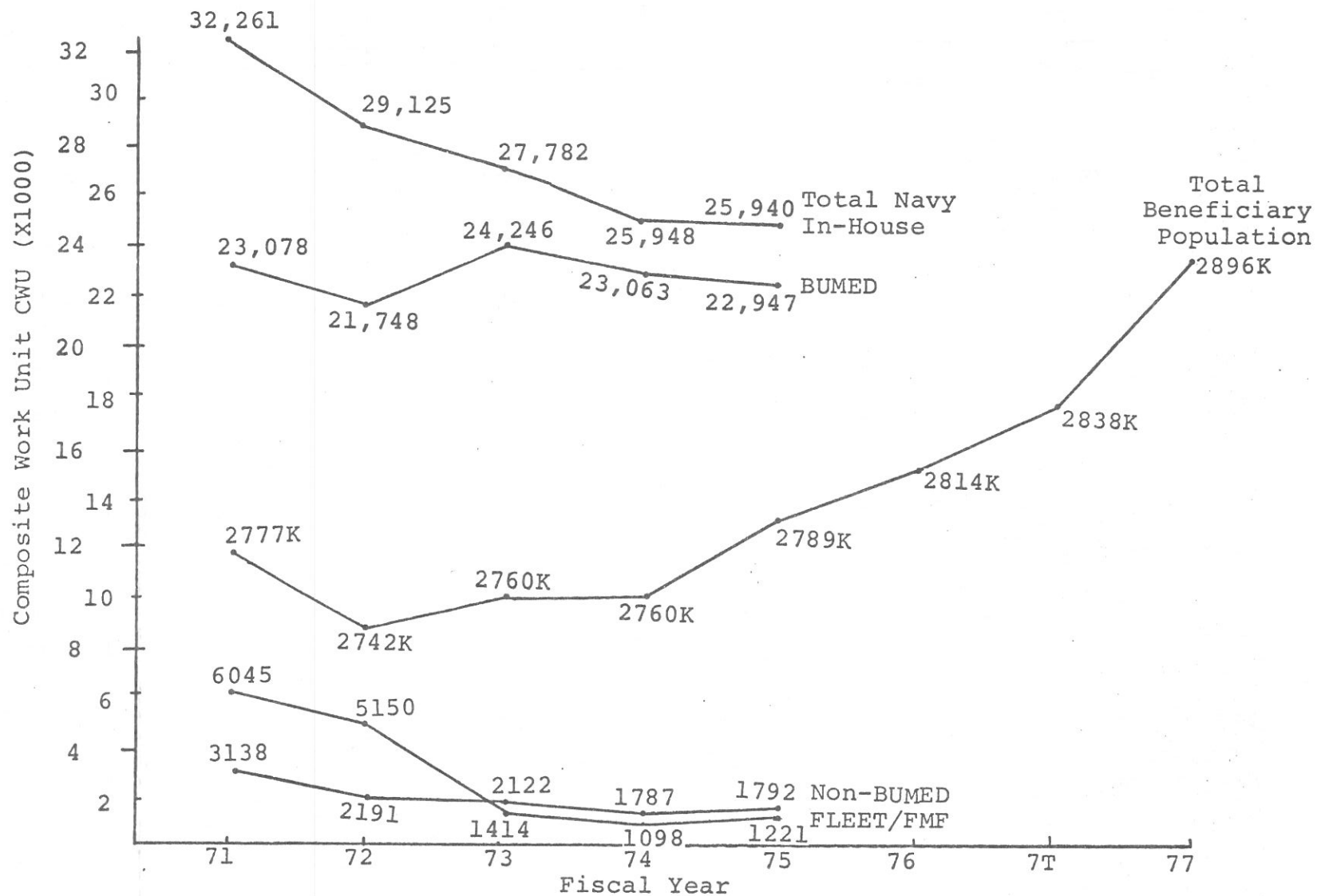
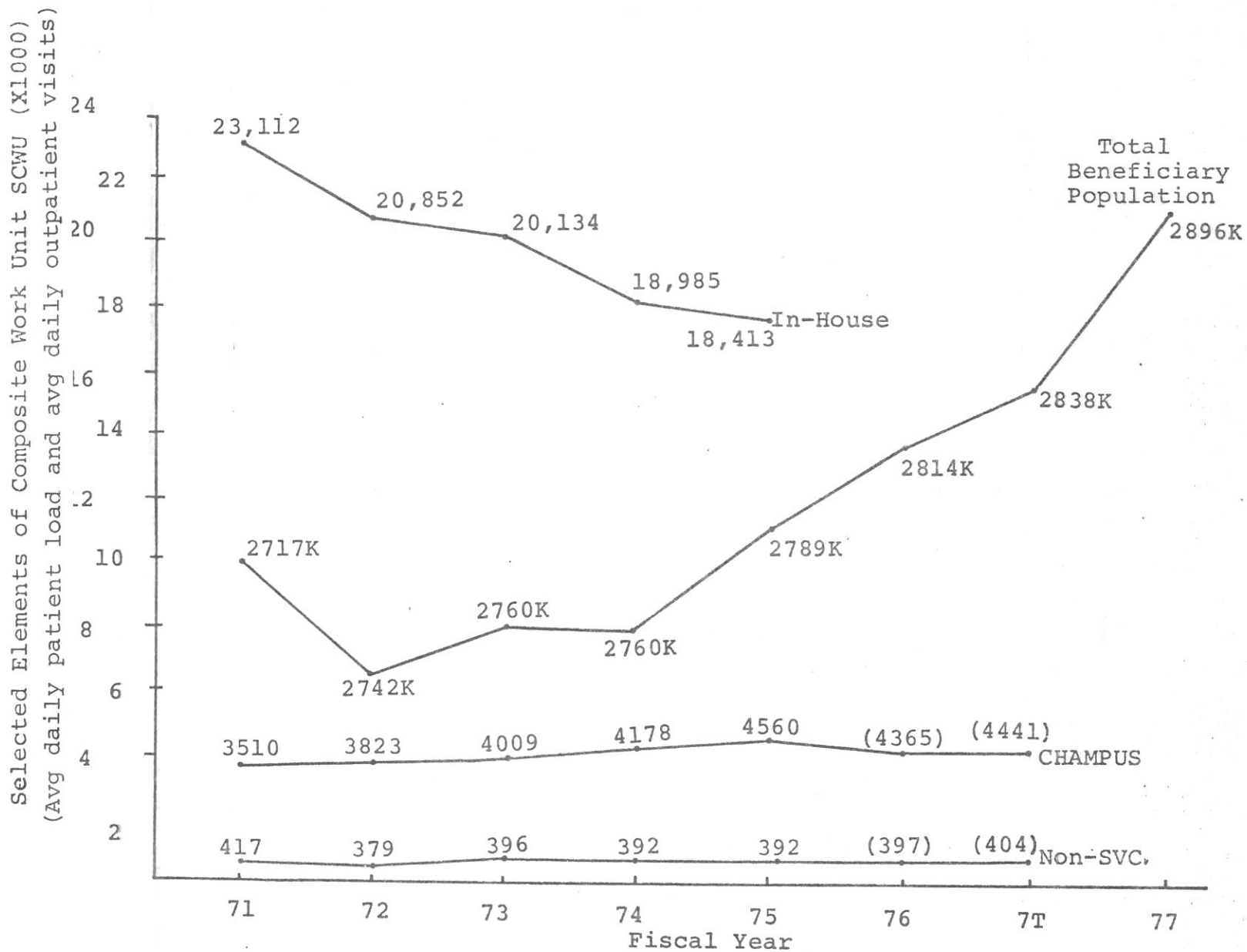


Figure A-3



() estimated data FY-76 OSD submit

Figure A-4

the same period when the dependent and retired beneficiary population has grown steadily. The rapidly escalating costs of health care in the civilian sector, and the conclusion of the OMB/HEW/DOD Military Health Care Study that more cost effective services are provided by the military health care facilities, strongly suggest that greater use of military facilities is necessary in order to achieve reductions in DOD health care costs. Figures A-3 and A-4 show just the opposite appears to have occurred.

This steady decline in reported workload (i.e., apparent under-utilization of available facility capacity) in Navy health care facilities for the period FY 71-75 has caused concern which has been precipitated by:

- Growing beneficiary population
- Escalating health care costs
- Overall budgetary reductions
- Continued use of civilian health care sources via CHAMPUS.

Many techniques and models have been used to forecast the workload in medical facilities. Each attempt has been frustrated due to either the lack of available data, the relative inaccuracy of the data gathered, or the number of undefined variables. Two key elements of predicting the future demand for services are an accurate population history and a complete record of work performed. As has been shown, the data gathered in support of each of these

elements is far from complete. Thus, attempts to predict demand workload must use various estimating techniques to approximate the missing or incomplete data.

Figures A-5-6-7 utilize the known population and the CWU workload data, to produce the estimates for FY 80, 85, and 90. The projection uses the calculated CWU and the known population for FY 71-75. It uses the trend curve for the five individual beneficiary categories to develop a percentage of the estimated population data from the OMB/HEW study. The five categories are plotted in Figures A-5 and A-6. The summation of this data is presented in Figure A-7. Although the scales have been arbitrarily chosen to accentuate the relative changes in each fiscal year, careful evaluation of the plots shows that the data is both reasonable and supportable. It must be remembered that the workload data plotted is CWU information which is not indicative of the total workload within the medical department facilities and population is the total of all beneficiary categories.

Note that Figure A-7 also plots a CWU workload per population ratio. Even with the accepted inaccuracies of the individual components of the data, it is felt that this ratio is most meaningful to planners. The high level in FY 71 appears consistent with the Vietnam high casualty era. Fifty-seven percent (140 per day) active duty personnel were hospitalized above the expected hospitalization

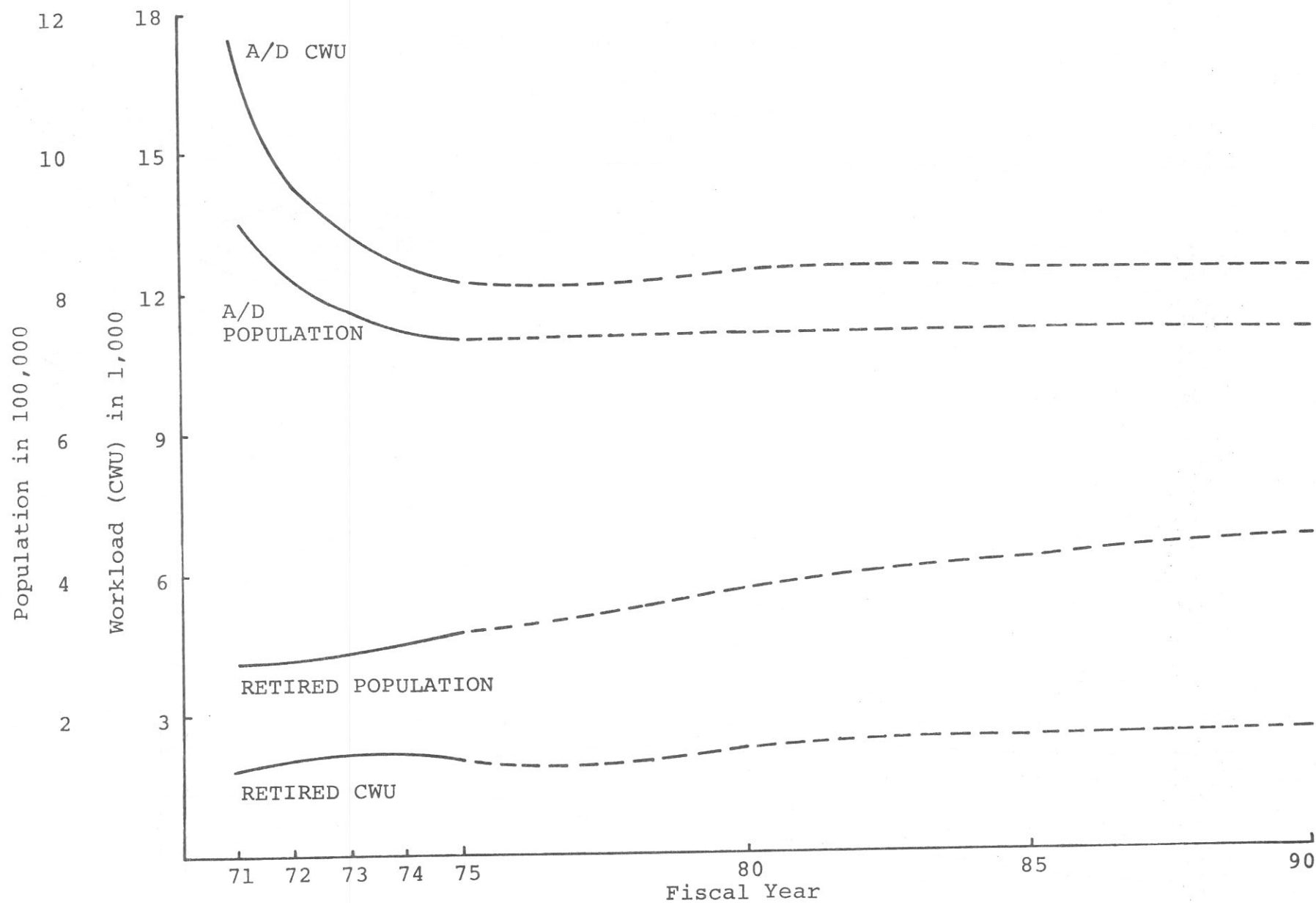


Figure A-5

POPULATION AND CWU WORKLOAD BY FISCAL YEARS

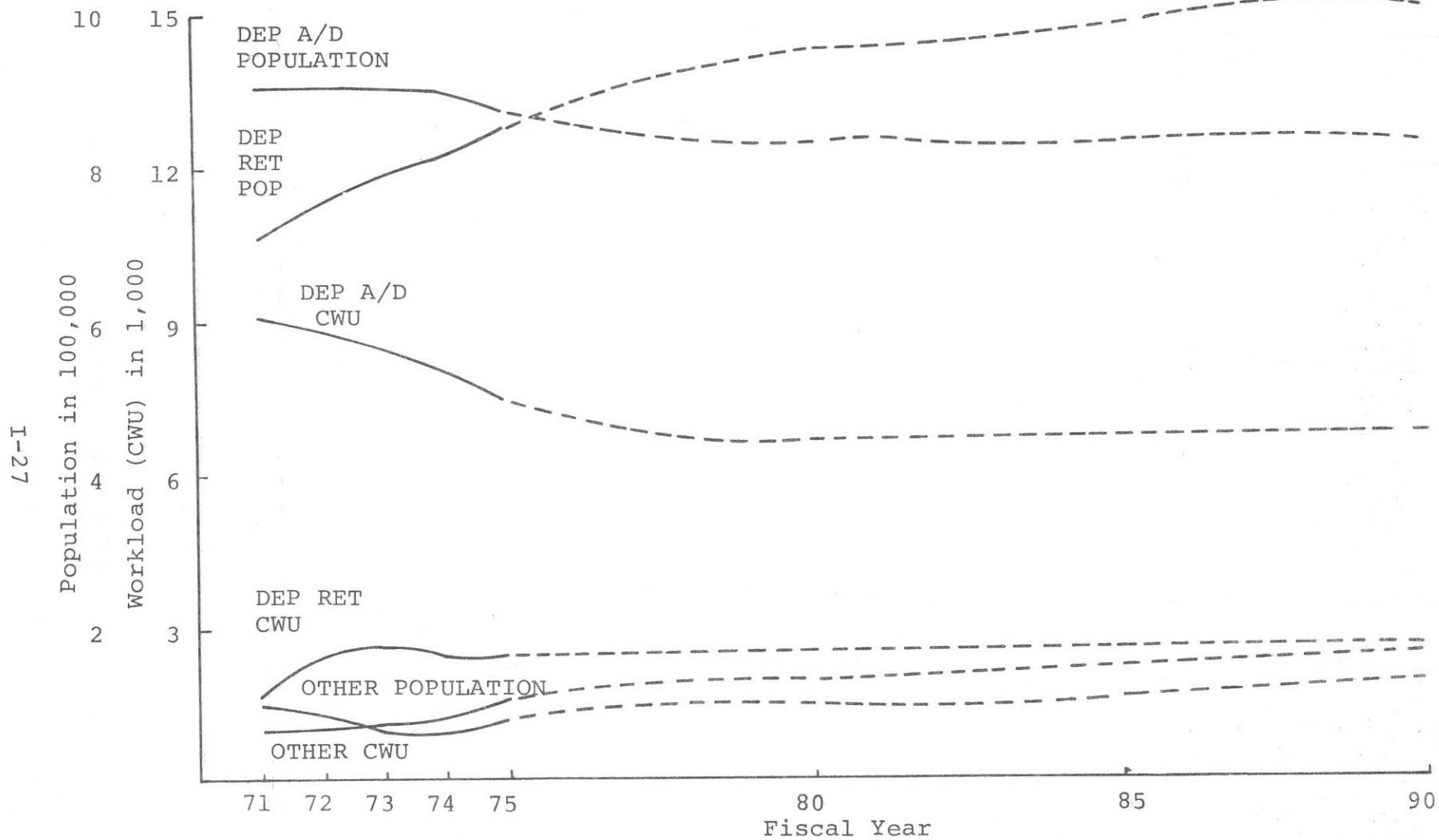


Figure A-6
POPULATION AND CWU WORKLOAD BY FISCAL YEAR

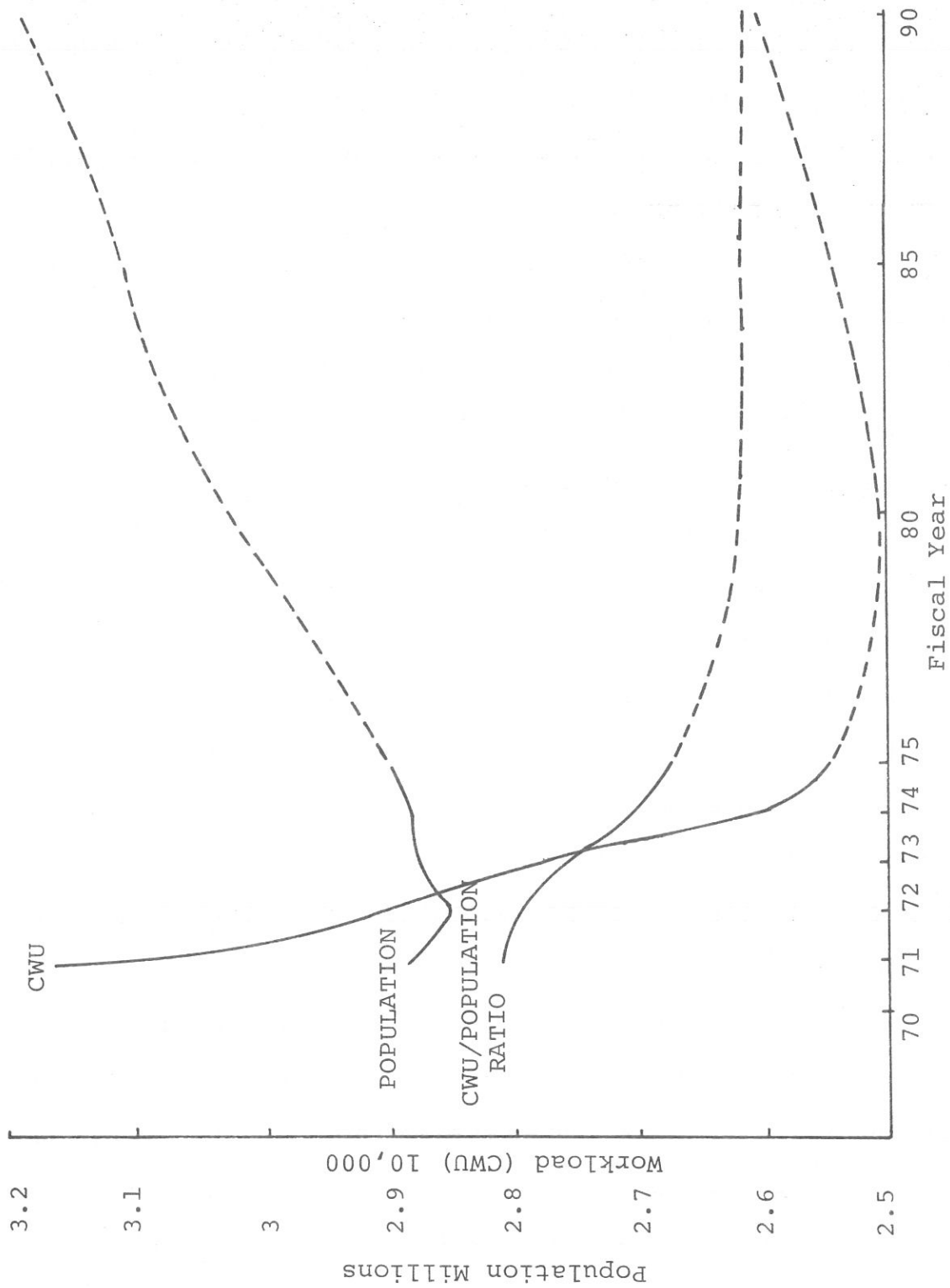


Figure A-7
CWU/POPULATION/RATIO

rate accepted by the medical community. The decline in the early 70's is largely the result of the wartime to peacetime conversion. The turning point that appears to be in progress with the projected leveling off by 1980 reflects the completion of the peacetime transition.

Without an acceptable standard, the fact that the CWU/population ratio ranges between .011 to .00815 in the 20 years depicted is meaningless. This ratio supports the premise of the relative non-effectiveness of using the CWU as a total measure of medical workload.

III. Conclusions

For all beneficiary categories we know:

- 85% of the number of beneficiaries accurately identified
- 78% of the location of the beneficiaries
- 50.5% of the age and sex of the beneficiaries

These percentages of known population data are less than adequate for precise health care planning. Massive workload data is collected by BUMED; collated and published quarterly. The data collected, however, are elements of the Composite Work Unit, a somewhat less than satisfactory measure of total medical workload. The estimations required with the present system are too encompassing for the purposes intended.

IV. Recommendations

1. It is essential in order to offset the notion of hospital under-utilization and to permit more effective

planning, that a formal population data collection system be established to include a quarterly extract to the Bureau of Medicine and Surgery from the files of:

- Bureau of Naval Personnel
- Commandant of the Marine Corps
- Navy Finance Center Cleveland
- Marine Corps Finance Center, Kansas
- Navy Reserve Training Center Bainbridge

2. Since there is no single collection point of this data, it is recommended that BUMED be so tasked. It is further recommended that CHBUMED be the source of Navy and Marine Corps health care population data, and be designated as Navy's representative for any interservice or OSD sponsored tri-service population collection effort.

3. A more meaningful and effective measure of medical workload must be devised to incorporate some indication of the relative intensity and complexity of health care provided. This is essentially an expansion of the existing CWU. Along with this expanded CWU, an additional measure is required to encompass the work performed by the medical department which is not directly related to patient care. This new measure should primarily be:

- Independent of patient accounting
- Independent of type of facility
- Independent of type of clinical procedure
- Standard throughout medical facilities

- Easily determined from available data
- Inclusive of all types of work accomplished

Once the improved CWU and new measures are devised, a standard should be identified as a basis for comparison of individual facility workload.

SECTION B

NHCRC REVIEW OF NAVY HEALTH CARE SUPPORT REQUIREMENTS

I. Introduction

The Navy Health Care Review Committee defined the term "Health Care Support Requirements." It further identified the differences between the traditional civilian health care support requirements and the Navy health care support requirements. This part of the overall review established the foundation for the categorization and evaluation of individual elements of the Navy's Health Care System.

II. Discussion

There is a misconception that a clearly stated definition exists of what constitutes the health care support requirements of any population. There may be individual intuitive ideas but in fact, there is no one published determination of health care support requirements which enjoys general acceptance or wide understanding.

It is difficult to define "Health Care Support Requirements," since each word of the phrase has many meanings. By using a few of the simplest definitions of the words, a complex set of possible definitions is generated. Figure B-1 depicts a synthesis of simple word definitions into an overall definition of the phrase "Health Care Support Requirements,"...the essential services necessary to protect individuals against the conditions of illness, disability or abnormality.

HEALTH CARE SUPPORT REQUIREMENTS (Definition)

"Health	Care	Support	Requirements"
1. Absence of disease	1. Concern for	1. To sustain	1. That which is needed or essential
2. Condition of freedom from illness, disability, or abnormality	2. Protection from	2. Provide with the means of sustaining life	2. Demanded or considered appropriate
		3. Serving as a foundation or basis	3. That which one cannot do without

That which one cannot do without in order to be provided the means of sustaining life; protection to insure the condition of freedom from illness, disability or abnormality.

Essential services necessary to protect individuals against the conditions of illness, disability or abnormality.

Figure B-1

The basic scientific discipline and art of Navy health care is derived from civilian health care principals as modified and amplified by military requirements. The requirements for health care support for Navy and Marine Corps personnel are found scattered in:

- Military, especially Naval, applicable Federal legislation.
- Department of the Navy regulations.
- Manual of the Medical Department.
- Related policy and guidance, and directives issued by headquarters and field activities of the Navy and Marine Corps.

A. Health Care Requirements, Civilian

In the civilian setting the requirements for health care support have been loosely described as that broad set of comprehensive health care services and capabilities which are available, can be provided to population groups or individuals, and are financially supported in multiple ways. These services may be rendered by individual providers or by the most complex of medical institutions. Berki provided in his work, Hospital Economics, an arbitrary classification of these services based upon their primary purpose. He has identified seven taxonomic categories of health services:

- Preventive
- Diagnostic

- Therapeutic
- Maintenance
- Ameliorative
- Research
- Medical (Dental) Education

These arbitrary separations in the civilian setting are subject to economic and social forces which create public demand for regulation and control. The characteristics, quality, and costs of these services are the result of years of societal behaviors and interactions of an affluent nation. The range extends from simple nutritional advice to the dedicated use of hundreds of thousands of dollars worth of health care support to a single individual. Thus, much of the health care support requirements in the non-Federal sector of our nation stem from wide pluralistic expressions and agreements between health care providers and patients, and recent influence of the purveyors of civilian health industry control.

The civilian setting permits a broad diversity of capabilities for both individuals and community health care services. These services are adjusted to accomodate the monetary variances of today's market. Furthermore, the accepted legal norm of health care is that which is in the patient's best interests or desires irrespective of cost. The civilian health care requirements are thus the manifestation of Berki's seven categories of services in

response to the desires of the patient or the recommendations of the providers.

B. Health Care Requirements, Naval

The health care support requirements of the Naval establishment have major parallels to the civilian environment. In the area of diagnosis and treatment of illness and injury, many health care practices of both communities are quite similar. For example, the indications for the need to administer antibiotics for selected infectious diseases remain the same. The indications for the need to perform a hysterectomy do not vary substantially from civilian standards. The requirement for usual immunizations is shared in both communities. With such examples one might assume that surely the Navy health care support requirements are essentially identical to the civilian requirements. This is not the case due to the particular differing characteristics and demands of the active duty Navy and Marine Corps forces. Historical experience, authoritative direction, and military tradition cause the Navy health care requirements to differ from that of the civilian community. This difference in the care provided lies in:

- The degree of the support provided.
- The extent of the care given.
- The emphasis of priorities.
- The extent of Navy line management orientations.

This difference becomes more evident when considering the foremost objectives of the Navy Medical Department, which are to:

- Safeguard and promote the health of active duty Navy and Marine Corps personnel.
- Care for and cure their illnesses, wounds, injuries, and many abnormalities.
- Achieve the maximum functional and physical conservation of the health of Naval personnel in the environments in which they operate.
- Insure medical department personnel are capable of immediate response.

There are no similarly constructed requirements in the civilian sector. Though Navy health care support has its clinical similarities to civilian clinical practices, it has a distinct difference in that the clinical personnel are members of the armed services operating in everchanging, unpredictable and potentially adverse environments. Furthermore, the Navy Medical Department provides health care support services to the Naval community within the constraints and priorities imposed by higher authority.

Navy health care support lies not only in the definitive clinical care aspects of diagnosis and therapy of illness but also includes emphasis upon:

- Health maintenance and health promotion services (preventive medicine).

- Health care and cure services in the areas of:
 - civilian equivalent support requirements
 - military environment (DNBI)
 - combat incurred casualties.
- Navy management and control of:
 - education and training
 - research and development
 - military planning and logistic support.

C. Medical Department Personnel Skill Requirements

The Navy medical department personnel must possess sufficient skills and capabilities to meet the health care requirements of the Navy and Marine Corps communities. These personnel must possess uniform proficiencies and competencies, consistent with each individual's level of accountability and responsibility and in accordance with rank/rate and skill designator. The common denominator in applying the respective health care skills is that medical department members must be skilled providers and:

Educators	}	of health care in varying degrees at every level
Counselors		
Advocators		
Ombudsmen		
Supervisors		
Managers		

Furthermore, all medical department skill capabilities must encompass a balanced application of the four definitional categories of health care support, namely:

- I - Patient care
- II - Preventive, environmental medicine
- III - Health care planning
- IV - Health care logistics

Such a balance must include certain knowledge of the characteristics and descriptions of both the Naval organization and its personnel. The application of Navy health care skills must be performed in all four categories of health care support with full cognizance of:

- The Navy and Marine Corps organizations
- The characteristics and descriptors of Navy and Marine Corps populations
- Attitudes in keeping with the recognized expectations of the line organizations.

The Navy Medical Department personnel must therefore perform their skills in terms of these separately identified but interdependent areas:

- Navy officer/enlisted (USN) skills,
- Navy health care support equivalent (NHE) skills, and
- Civilian health care support equivalent (CHE) skills.

Appendix C of Volume II provides definitive examples of selected types of skills required for the various assignments of the Medical Department personnel in different levels of responsibilities of typical positions. The examples are restricted to selected capability requirements and are not to be construed as all inclusive. They do not depict the full range of required proficiencies and competencies.

III. Conclusions

There are significant differences between the ordinary civilian health care requirements and those of Navy health care. The differences are generally not within the clinical areas of the broad field of medicine but are within the emphasis, degree, and orientation of meeting the health care requirements. The skills necessary to satisfy these requirements include the clinical expertise of the civilian sector as well as a discrete capability beyond that demanded of the civilian health care provider.

This review resulted in the NHCRC defining the Navy Health Care Support Requirements as:

"The need to safeguard and promote the health, care for and cure the illnesses, injuries, wounds, and many abnormalities of Navy and Marine Corps personnel and other beneficiaries; by providing preventive, diagnostic, therapeutic, maintenance, ameliorative, technical research, and professional education services at primary, secondary, and tertiary health units

and facilities; to insure the maximum conservation of functional military personnel in their everchanging operating environments; using medical department personnel that are capable of immediate response; all within the priorities, limitations, and resource constraints provided by Navy line management policy and plans of action."

IV. Recommendation

It is recommended that the definition of "Navy Health Care Support Requirements" be adopted by the Surgeon General to the greatest extent possible as the basis upon which to evaluate and appropriately balance the orientation, skills, and capabilities of Navy Medical Department personnel.

APPENDIX C

EXAMPLES OF PROFESSIONAL PROFICIENCIES AND SKILL COMPETENCIES

1. Naval Medical Officer (NMO)
2. Naval Dental Officer (NDO)
3. Naval Medical Service Corps Officer (NMSCO)
4. Naval Nurse Officer (NNO)
5. Naval Enlisted Hospital Corpsman (HM)
6. Naval Dental Technician (NDT)

SECTION C

NHCRC REVIEW OF NAVY MEDICAL CONTINGENCY REQUIREMENTS (MEDCON) STUDY

I. Introduction/Background

Contingency requirements for health care support are the basic, underlying factors in the development, sizing, organization and ongoing operations of the Navy Health Care System. This section of the report discusses the current methodology by which the Navy determines its medical contingency requirements. The Navy Medical Contingency Requirements (MEDCON) Study conducted in FY 1975 provided the Navy with an updated methodology (the MEDCON Model) for computing these requirements. The MEDCON model represents an ongoing current initiative on the part of CHBUMED.

A summary of the currently programmed requirements produced by the MEDCON model is contained in NHCRC Volume III (classified SECRET).

II. Discussion

The purpose of the MEDCON Study was "to develop an appropriate data base and an ADP model which would be sensitive to given Navy scenarios and contingency plans and which could generate a documented, quantified statement of medical contingency requirements."^{1/} Casualty rates were

^{1/} Abstracts of Past Studies on Health Care Systems, (MEDCON) DOT Systems Inc., Vienna, VA., 16 Sep 1975 (ONR Contract N00014-74-C-0281).

determined from those force strength levels stated in the Five Year Defense Plan (FYDP). Planning factors were derived from historical data, the USMC Mid-range Plan, and application of modifiers determined by the SEAMIX analyses. The Study specifically addressed the Defense Program Planning Guidance (DPPG) contingency scenario.

Selection of basic data to be applied to a given scenario, and equating these data with the force strength involved in the operation (under any given degree of combat activity), will provide an ADP output of average daily, interval, and cumulative determinations of admissions, returns to duty, evacuations, beds occupied, beds (facilities) required, and the medical personnel required to support a specific operation.

The formula employed in the MEDCON Model is the same as that which is reflected in doctrinal publications and which has been manually used for many years: force strength X admission rate X accumulation factor X dispersion factor = beds required.

Significant weaknesses in the MEDCON Model are its inability to readily provide data which reflect surges of casualty experience, and its sensitivity to human judgment error when the basic model data is selected for manipulation. Accuracy and speed are the significant gains achieved through the MEDCON Model, which allows for timely determination of resource requirements.

Tables A-1 through A-4 of Appendix A of Vol. III, reflect the utility of the MEDCON model arriving at resource requirement determinations. The executive summary and the unclassified portion of the MEDCON Study report are attached as Appendix D, Volume II.

III. Conclusions

The MEDCON Model is an efficient manipulatable ADP planning process for determining medical personnel and facilities resources required to support operational contingencies.

IV. Recommendations

That CHBUMED continue efforts to expand the MEDCON model to a follow-on MEDCON-II Study which will develop a conceptually updated and more analytically sophisticated approach to generating medical contingency requirements.

APPENDICES

VOLUME II-D

- Executive Summary to and complete report of Rationale for Requirements Determination
- MEDCON Study Final Report, Draft Revision

VOLUME III-A

- Executive Summary to and complete report of Rationale for Requirements Determination
- Time Phased Navy Medical Department Personnel Requirements, Active Duty Care Only
(SECRET--Vol. III)

SECTION D
MARINE CORPS HEALTH CARE
SYSTEM REQUIREMENTS

This is an UNCLASSIFIED ABSTRACT
of
SECTION I (SECRET), found in VOLUME III.

I. Purpose

To define the health care requirements necessary to support Fleet Marine Force task organizations operating in varying degrees of conflict intensity from either a shore or seabased service support posture.

II. Discussion

A. The Health Care System necessary to support FMF operational requirements was defined and analyzed in consonance with the Marine Corps Mid-Range Objective Plan, existing doctrinal publications and the developing Seaborne Logistics System (SMLS) concept. The major areas addressed are medical and dental support requirements; control and communications; organization for landing force medical service; medical and dental supply, material, and equipment and facilities.

B. Medical and Dental Support Requirements center on the maintenance of health efficiency of the troops. This support encompasses the classical functions of collection, emergency treatment, temporary hospitalization, evacuation

of the sick and wounded, and technical supervision of sanitation and preventive medical practices. It must be responsive to the substantial difference in health care support required in a shore based or SMLS environment.

The degree of support is determined by the types of casualties sustained (combat or DNBI) and factors affecting the health care system after the casualty occurs. These factors include: percentage evaluated; evacuation policy; patient admission rate; accumulation rate; and dispersion factors.

C. Future operations require that medical/dental support of the FMF be more flexible; capable of rapid response; and conform to the Marine Corps mid-range concept of seabasing to include low-/mid-intensity crises and counter insurgency situations. These needs require centralized control and coordination of casualty distribution among the various medical/dental facilities.

1. Control is concerned with medical regulating and casualty evacuation control required to minimize the delay between injury and the commencement of definitive treatment during a combat operation. This includes supervision of the total medical effort, overall control of medical units, coordination of all medical functions, and coordination with elements and agencies tasked to provide support for medical functions. It includes control of

casualty distribution and the dispatch and destination control of air and surface vehicles. Finally, control includes problems relating to the movement of patients after wounding, and secondary movement after stabilization to more sophisticated medical facilities.

a. During the mid-range period, the ATF surgeon will monitor and coordinate all major medical/dental functions, and provide direction and control of the medical/dental elements which provide support for the LF in tactical operations.

b. This control and coordination of medical/dental assets may be passed ashore when medical communications have been established and when mutually agreed upon by the Force Commanders.

c. Upon transfer of responsibilities ashore the LF surgeon will assume the monitoring and coordinating functions.

2. Medical regulating is required to ensure that all patients receive the most expeditious and effective medical care possible, and that their onward evacuation is accomplished promptly with regard to maximum utilization of capable medical and transportation assets. This function will be accomplished through a medical regulating agency (MRA) which would function as a medical operations center in the MCCC or MSCC to coordinate the movement of casualties

from the battlefield to the medical facilities; provide liaison officers to HDC/DASC; maintain current status and capability of medical facilities; record completed medevac missions; provide casualty alerts; coordinate JAMRO or ASMRO lateral or onward moves; and monitor all medical comm nets.

3. The need for efficient utilization of helicopter assets during the mid-range period and the uncased emphasis on directing combat casualties to the medical facility best disposed to provide definitive care requires rapid, responsive and reliable communications. Communications must be maintained with and among: adjacent medical facilities afloat and ashore; agencies controlling medevac vehicles (air, land and waterborne); casualty evacuation vehicles; transport units for onward evacuation; ATF surgeon; LF surgeon; and MRAs.

The medical and dental organizations of the FMF provide the framework for managing and employing medical/dental support assets. Their primary mission is the conservation of combat power of the command with which they serve. This is accomplished through technical supervision of measures designed to safeguard the health of the command, early effective care of the sick and injured, and prompt and orderly evacuation of casualties from forward areas. Their principal duties are: administration of first aid;

performance of emergency surgery; collection, transportation, sorting, temporary hospitalization, and evacuation of casualties; and, technical supervision of measures designed for the prevention and control of disease. Emergency surgery and temporary hospitalization are considered particularly significant because the words "emergency" and "temporary" qualify the type and amount of medical support to be expected from organic FMF medical units. These qualifications establish that FMF units must have external support to provide complete care for medical casualties. During the initial states of an amphibious operation, additional support is provided by ships of the ATF. As airfields are established during subsequent operations ashore, evacuation to theater and CONUS hospitals is provided by Air Force aircraft. Advanced base hospitals, hospital ships, and Army hospitals must provide additional support for sustained FMF operations ashore. The current FMF organizations for accomplishing the medical/dental support tasks are shown in Table D-1. This summarizes the principal capabilities and responsibilities of FMF medical sections/units, as well as those for supporting activities.

E. Medical/dental supply support requirement for the FMF during the mid-range period will not decrease, but will change appreciably through the use of improved, more sophisticated and environmentally controlled medical care

TABLE D-1

(U) FMF MEDICAL/DENTAL UNIT
CAPABILITIES & RESPONSIBILITIES

Unit	First Aid	Est. Evac. Station	Surgery	Temp. Hospital	Evacuation Grd. Sea Air			Ext. Care
Unit Med. Sections	X				X			
Inf. Bn. Med. Plt.	X	X			X			
Med. Bn.			X	X	X			
Hospital Co.			X	X				
Dental Co.	X		X					
MAG (VH)							X	
VMGR							X	
ATF			X	X		X		
USAF							X	
Theater Hosp.				X				X
CONUS Hosp.								X

facilities for combat casualties. The SMLS concept will affect the quality and responsiveness of medical support to FMF's by the extensive use of medical facilities aboard ships of the assigned task force.

Traditionally, non-volunteer, non-motivated personnel have been assigned to the medical supply section of the support units. Additionally, most naval personnel so assigned are not Marine Corps supply trained, nor are they familiar with automatic data processing techniques, while most Marine personnel are not familiar with medical terminology, supplies, or equipment. Any single factor or combination of these factors would adversely affect the quality and responsiveness of medical supply support.

Modern medicine and dentistry, with new techniques and equipment, dictate that the sound practice of field medicine and dentistry requires definitive care of the sick and injured, rather than mere lifesaving procedures. Control of the environment greatly improves the physiological stability of the seriously ill or injured patient, and further enhances his chances of survival and eventual recovery.

The present equipment and tentage authorized for division, wing, and force level medical/dental facilities are outmoded and not conducive to the practice of modern techniques, nor do they permit full utilization

of the professional capabilities of the present day Medical Department personnel. However, the Marine Corps is presently conducting research into new types of medical shelters which will provide the environmental controls required, and which will meet the International Standards Organization limitations imposed upon it.

III. Proposed Initiatives

A. Medical and Dental Support Requirements

1. Medical and Dental requirements in support of planned FMF operational configuration must be considered when establishing ATF mission capabilities and facility configurations.

2. Priority should be given to assigning Medical Corps personnel to FMF operational billets in a manner that will either alleviate the present shortages identified in Table D-2 or at least not place an unacceptably disproportionate burden on the FMF component of the naval services.

B. Control and Communications

1. That agreement be reached, and a clear definition be given as to who has control of the medical/dental assets while operating under the SMLS concept.

2. That an additional medical regulating net be established for use by the surface control craft when being utilized for medical evacuations.

TABLE D-2

MC SUPPORT OF FLEET OPERATIONS AS OF 31 AUGUST 1975 (U)

	LANT FLT	PAC FLT	CVA's GEN SURGs	SUB MED	NMCBS	OVER- SEAS SHORE	CONUS SHORE	FLEET AVIATION LANT PAC	SHORE OVER- SEAS	SHORE CONUS	FMF GEN	FMF AIR	
2100 BILLETS:	53 ==	49 ==	15 ==	62* ==	9 =	79 ==	30* ==	36 ==	44 ==	12 ==	33 ==	140 ===	59 ==
2100 <u>DISTRIBUTION:</u>													
UNIT ASSIGNMENTS:	21	21	15	57	4	65	20	24	29	11	23	52	23
FLEET MANAGED POOLS:	16	17	0	0	4	0	0	0	0	0	0	0	0
NRMC MANAGED POOLS:	14	9	0	0	0	0	0	0	0	0	0	0	0
NRMC SUPPORT (AVMED):	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>3</u>	<u>4</u>	<u>0</u>	<u>1</u>	<u>0</u>	<u>3</u>
<u>TOTAL:</u>	51	47	15	57	8	65	20	27	33	11	24	52	26
<u>2100 DEFICIT:</u>	2	2	0	5	1	14	10	9	11	1	9	88	33
STAFFING RATIO:	96%	96%	100%	92%	89%	82%	67%	75%	75%	92%	73%	37%	44%

3. That a study be undertaken to determine the feasibility of providing the LF medical units with equipment and authorization to operate voice/wire secure communications.

C. Organization of Landing Force Medical Services

1. Medical Department personnel education and training should be oriented towards stressing the unique medical/dental requirements related to the classical functions of medical/dental support identified in Volume III, Section I. Educational curriculum as well as training methods should be established to be responsive to an operationally sensitive environment to the maximum extent possible.

2. That the Navy Medical Department review the "wet-dry" assignment policy in view of the lack of experienced personnel it causes to be assigned to the FMF.

D. Medical and Dental Logistics

1. That the SMLS concept be refined to reflect specifically the medical supply responsibilities of the ATF and LF commanders.

2. That the Field Medical Service Schools provide an appropriate instructional block covering basic Marine Corps supply procedures.

3. That the Marine Corps Supply School institute a block of instruction relative to medical supply, and emphasize participation in medical supply procedures within the present system.

4. That the Naval Medical Material Command continually upgrade AMALs for supply and resupply blocks to reflect current practices; and that Medical Specialists participate in the effort.

5. That the Marine Corps continue in their effort to design and procure medical facility shelters in which environmental control can be achieved.

IV. Conclusions/Recommendations

A. Conclusions

1. The Health Care System available to support projected FMF operational requirements is inadequate in terms of the trained personnel (organic or in regional centers) and responsive facilities (afloat or ashore) necessary to deal with any form of contingency situation in which FMF units are expected to sustain casualties.

2. The objectives and orientation of the present Health Care System do not reflect the proper degree of sensitivity to the concept of priority service to operational units of the FMF in the form and degree that would make the system mission oriented.

3. With the continuing imposition of even greater manpower and funding constraints on the present Health Care System, the system as it presently exists will become either more unresponsive to the unique requirements of the FMF, or provide a level and quality of service

that might be described as "second best." This will in all likelihood further increase the gap (real or perceived) in allocation of resources given to the FMF in comparison to Navy units. (As illustrated in Table D-2.)

B. Recommendations

1. That FMF health care support requirements be met or at least be given the same priority and consideration that Navy requirements receive.

2. That Medical Department personnel education and training programs be reviewed to insure those assigned to the FMF and those identified as augmentation forces receive the proper orientation and training and understanding of Health Care support considered unique to FMF operational requirements.

3. That CHBUMED initiate and maintain frequent and prescribed contact with CMC in order to ensure that both quantitative and qualitative health care support is provided to the FMF based upon both peacetime and combat requirements.

SECTION E

NHCRC SUMMARY OF FLEET HEALTH CARE SUPPORT REQUIREMENTS

I. Purpose

To identify fleet operation health care requirements and place them in their proper perspective in the Navy Health Care System.

II. Discussion

A. The NHCRC held a joint workshop with representatives of Fleet CINC's during the period 3-7 November 1975. Fleet health care requirements were addressed in the workshop through use of a problem identification and statement development technique.

B. Problem areas relating to the Health Care requirements of the fleets were revealed during the workshop from four major sources. The Fleet responses to a NHCRC prepared questionnaire (Volume IV) identified problems in the areas of communications, resource allocation, training, fleet pool/regionalization/augmentation, casualty facilities for the ATF and LF, and contingency planning. Problems identified and addressed during the workshop by draft problem statements included those related to ATF support, NRCM responsiveness, Medical Department training, preventive medicine, and the upgrading of education and training of non-medical personnel in the operating

forces in the area of health care. Each of the problem areas identified was discussed during the workshop. The problems as well as the actions initiated during the joint workshop are presented in Figure E-1.

C. Health Care Support to the Operating Forces:

This was of course the major theme of the NHCRC/FLTICINC workshop; the proceedings were replete with discussions of the responsiveness of the shore based Navy health care efforts to the needs of the Fleet. The problem areas seem to fall into three basic areas: availability of health care services; responsiveness to the unique problems of deploying units; and communication between and among the several facilities of NAVREGMEDCENS, the active duty personnel of the fleet, and the fleet commands themselves. The NHCRC Objective Statement on this subject contains the recommendations of the Committee to "fix" the problem; the statement incorporates the recommendations proposed by the fleet representatives attending the joint workshop.

D. Preventive Medicine:

The general area of Preventive Medicine (defined as in NHCRC Category II) was viewed by the workshop members as an area of significant deficiency in the current Navy Health Care System. The fleet representatives argued for an increased emphasis in this area in order to provide a capability within the Navy to rapidly identify, evaluate, and address potential threats to the health of Naval personnel.

SUMMATION OF NHCRC/FLEET JOINT WORKSHOP ACTIVITIES

Problem Areas	Level of Action Initiated		
Major Source			
<u>Fleet Responses to Questionnaire</u>	<u>Discussed</u>	<u>Analyzed</u>	<u>Action Steps Formulated</u>
Communications	X		
Resource Allocation	X	X	
Training	X	X	X
Fleet Pool/Regionalization/ Augmentation	X		
ATF & LF Casualty Facilities	X	X	X
Contingency Planning	X		
<u>Identified and Addressed During Workshop</u>			
ATF Support	X	X	X
NRMC Responsiveness	X	X	X
Training	X	X	X
Preventive Medicine	X	X	X
Non-Med E&T	X	X	X
M.O. Responsibilities	X	X	X
+ Billets	X	X	X
Medical Augmentation Terms	X	X	X
Availability of Organic Personnel	X	X	X
<u>Presented by Fleet Representatives</u>			
OPTAR Control	X		
NBC/Adverse Weather Training	X		X
I.D. Corpsmen	X	X	
Health Status of Recruits	X		
Overseas Dependent Health Status	X	X	

FIGURE E-1

SUMMATION OF NHCRC/FLEET JOINT WORKSHOP ACTIVITIES (CONTINUED)

Problem Areas	Level of Action Initiated		
Major Source			
<u>Evidenced During Workshop Discussions</u>	<u>Discussed</u>	<u>Analyzed</u>	<u>Action Steps Formulated</u>
Command Relationships	X	X	
Common Definitions	X		
Effective Employment of Medical Officers	X		
Implied Threat to Care for Non-Active Duty Beneficiaries	X		
100% Fill of Operational Billets	X	X	X
Aviation Fatalities	X		
ABFC Control	X		
FMFLANT Health Care Delivery	X		
Review of AMAL's	X		
NRMIC Patient Control	X	X	
Medical Officers Perceptions	X	X	

I-62

FIGURE E-1 (CONTD)

Such a capability seems implicit in the medical department mission "to safeguard and protect the health of Navy personnel" (as well as provide the "care and cure" for the sick and injured). The Committee concurs in the need for such additional emphasis. Interestingly enough, it appears that the basis for the data base, evaluation mechanisms, and communication of findings already exists in BUMED, Navy Environmental and Preventive Medicine Units, Disease Vector and Environmental Control Units, the Navy Environmental Health Center and in the fleet. What appears to be lacking is an overall policy guidance and formulated program of Preventive Medicine (in the larger sense of the term) which is contained in the NHCRC definition thereof. Accordingly the Committee has formulated an Objective Statement on Preventive Medicine.

E. Augmentation Training:

The workshop proceedings include substantial discussion of problems in the amount, orientation and timing of training for Medical Department personnel who comprise the augmentation capability for the fleet and FMF. These problems and recommendations to resolve them have been incorporated into Section D, Chapter 5, Volume I on Medical Department Education and Training.

III. Conclusions

A. The Committee review of Fleet Health Care Support has identified problem areas which exist in responsiveness of the health care system to the needs of the operating forces.

B. Resolution of the responsiveness problems will stem from increased emphasis upon, and attention to, the health care requirements of the operating forces. Two Navy Health Care Objective Statements were developed by the NHCRC to provide a structured focus of emphasis and attention upon fleet requirements.

IV. Recommendations

That highest priority be given to the implementation of the attached Navy Health Care Objectives Statements:

#1 Health Care Support for the Operating Forces, Figure E-2

#4 Preventive Medicine, Figure E-3.

HEALTH CARE OBJECTIVE STATEMENT

1. HEALTH CARE SUPPORT TO THE OPERATING FORCES

"SURGEON GENERAL ISSUE POLICY
GUIDANCE TO ENSURE THAT HEALTH CARE
SUPPORT TO THE OPERATING FORCES OF THE
NAVY AND MARINE CORPS IS THE HIGHEST
PRIORITY OF THE NAVY HEALTH CARE SYSTEM."

AREAS OF CONCERN:


- 
1. HEALTH CARE SUPPORT PRIORITIES
 2. RESPONSIVENESS OF HEALTH CARE
SYSTEM TO THE OPERATING FORCES
 3. HEALTH CARE SYSTEM COMMUNICATION

FIGURE E-2

HEALTH CARE OBJECTIVE STATEMENT.

4. PREVENTIVE MEDICINE

AREAS OF CONCERN:

"CHIEF, BUREAU OF MEDICINE AND SURGERY INCREASE THE EMPHASIS ON THE PREVENTIVE AND ENVIRONMENTAL MEDICINE COMPONENT OF NAVY HEALTH CARE SUPPORT BY DEVELOPING AN EFFECTIVE CAPABILITY FOR THE TIMELY IDENTIFICATION AND EVALUATION OF HEALTH RISKS IN ORDER TO PROVIDE THE LINE ORGANIZATION WITH THE CAPABILITIES TO MINIMIZE THE EFFECTS OF HEALTH RISKS TO NAVY AND MARINE CORPS PERSONNEL."

1. IDENTIFICATION OF HEALTH RISKS TO PERSONNEL
2. RISK NEUTRALIZATION
3. EFFECTIVE COMMAND APPLICATION

FIGURE E-3

SECTION F

NHCRC REVIEW OF MEDICAL FACILITIES TO SUPPORT AMPHIBIOUS TASK FORCE/LANDING FORCE (ATF/LF) COMBAT OPERATIONS

I. Purpose

The NHCRC reviewed the health care facilities requirements and capabilities to support an amphibious landing. Shortfalls were identified and a combination of recommendations developed.

II. Discussion

Medical facilities required to be provided ashore and afloat in support of an amphibious landing were examined in detail, capabilities described, and shortfalls/deficiencies revealed. Sources of support analyzed included Amphibious Task Force ships, other alternatives to Hospital Ships, medical facilities organic to the USMC Landing Force, and advance base functional components. Aeromedical evacuation was briefly discussed.

III. Conclusion and Recommendations

The conclusion and recommendations are contained in Volume III of this Review due to SECRET classification.

SECTION III

Health Care System Influences
Relationships

Section A - NHCRC Review of Civilian Influences and
Relationships Upon the NHCS

Section B - NHCRC Review of the Nature and Impact of Non-Navy
Federal Influences and Relationships upon the NHCS

SECTION A

NHCRC REVIEW OF CIVILIAN INFLUENCES AND RELATIONSHIPS UPON THE NHCS

I. Introduction

The Navy Health Care System (NHCS), as an organized body which engages in diverse and complex health activities, does not operate and provide health services within a vacuum solely as a technically and professionally isolated military component of the Naval branch of the Armed Forces. As an organized body within the Navy, the Navy Medical Department has both clear and nondistinct lines of Navy authority and federally directed guidance by which it functions to plan and provide a spectrum of health services. Complex as those internal Naval relationships are, Navy health care activities also have distinct and some distant relationships, interfaces, and interactions with the non-Federal community. They encompass a range from individuals to organizations, to communities, to counties, to states and finally to the nation itself. The nature, extent, character, and necessity of these non-Federal relationships constitute both actual and working presumptions by most persons directly engaged in Navy health care responsibilities. Such presumptions bewilder those not so engaged.

Diverse, complex, and even mystifying as are the NHCS's relationships with civilian health bodies, agencies, and

communities individually and at large, this review explores the nature, extent, and purposes of these relationships. These relationships were viewed from an historical perspective, their composition, the levels of operation, their purposes, what they provide, and their importance. Purely individual non-Federal relationships were not dealt with in contrast to the more important consideration of the thrust and impact of the aggregate bodies of voluntary organizations upon the Navy Health Care Systems. From this consideration of the interplay of forces, it was possible to reflect general dimensions of relationships with a simply constructed but demonstrative conceptual framework.

II. Historical Perspectives

The development of regulatory controls over health practitioners has been reported upon extensively in the available literature.^{1/} Voluntary controls for physicians emanated originally in history from ethical expressions; e.g., the well-known Hippocractic Oath, the guild criteria of the Barber-Surgeon Guild in England in the middle 1500's, etc. These evolved into the current guidelines issued, for example, by the Ethics Committee of the American Medical Association.

^{1/} Eliot Friedson, "Profession of Medicine," Dodd, Mead and Company, New York, 1973.

Prior to the 1850's few major health benefits could be achieved through the available body of applied knowledge of diseases, injuries, and abnormalities. The qualities and capabilities of personal compassion far exceeded those of cure. Concurrent with the exponential growth of scientific biologic, surgical, and medical technology from the late 19th Century to the present, massive incursions of applied health knowledge have markedly altered the health and quality of life of individuals, armies, and nations.

Associated with the technologic growth of scientific capabilities appeared significant impacts expressed as governmental priorities by prestigious reviewing commissions and agencies, and by individual professional societies and organizations. Pivotal in the recognition that medical education was woefully inadequate by lacking a scientific base, the Flexner Report, in 1910, stimulated the formulation of regulated, structured, and extensive scientific based medical education. Further scientific recognition of applied medical knowledge led to the earliest recognition of the need for specialization in the 1920's.

The essence of voluntarism in the assessment of health activities and education actually antedated the Flexner Report. Based upon the traditionally American characteristics of independence and initiative to document and

preserve worth and value, the first regional associations of United States Colleges were formed in the latter part of the 1800's.^{2/} Their objectives were outlined as:

1. To provide communication and the exchange of ideas.
2. To provide standards as requisites for membership.
3. To provide comparative criteria of excellence.

Preceding even this citizen effort, in 1847 the American Medical Association organized with a basic belief in the need to elevate standards of medical education in the United States. By 1905 this same organization developed an authoritative body called the Council on Medical Education and Hospitals and convened its first national conference on medical education. From this conference evolved the formulation of standards and the institution of school surveys.

Following the 1910 Flexner Report, the AMA and Association of American Medical Colleges (AAMC) enforced the process of review, education and certification of schools. This enforcement of rigid standards and criteria by the Liaison Committee on Medical Education (made up of representatives of these organizations) is the ultimate form of accreditation for every U.S. medical school today. Official accrediting recognition of this activity has

^{2/} C.H. William Ruhe, "The AMA's Program of Accreditation in Continuing Medical Education," presented in Chicago, 1963.

been delegated by the National Education Regulatory Authority, the U.S. Office of Education.

In 1912, independent voluntary accreditation of internship by the AMA Council of Medical Education and Hospitals was formally initiated and in turn was followed shortly by state legislative action requiring at least one year of internship in an approved hospital as requisite to licensure. The purposes were simple, but profound. By enforcing specific prerequisites to licensure, the public could presume minimum essential levels of health professional competency.

By 1920, evolving specialization in medicine led initially to the establishment of separate committees to assess the requirements for and preparation essential to secure expertness in each of the then recognized 15 medical specialties. This voluntary amalgam of representative interests provided the first list of approved medical residency positions in the United States. This original number can be compared with a recent list of total positions in 1972 and 1975, as seen in the table below.

1927	1,699 residencies
1972	51,530 residencies
1975 ^{3/}	75,357 residencies

^{3/} Directory of Approved Residencies 1974-75.

The procedural mechanisms of approval of these programs require extensive periodic site surveys and review to assure satisfactory meeting of standards published by Residency Review Committees. Today, these committees are comprised of member representatives of the AMA, Specialty Boards, and major national professional societies.

Virtually all non-Federally constituted professional organizations originated voluntarily from the need to develop collegueship, express and promote collective interest, and document a sense of public accountability as related to each area of professional interest. Within the U.S. these medical societies and organizations have contributed vastly to the quality of health care, education, and research. In turn, both the individual and the aggregate health of this nation's populace has improved. The record established by this pluralistic maze of professionally oriented volunteer organizations has been sufficient to warrant common recognition by Government, most organized segments of the public, and most members employed in health care fields. Though emphasizing a medical perspective above, the preceding developments followed in similar evolutionary patterns in the Dental, Nursing and Allied Health Professions.

Aside from promoting and enhancing education and the scientific practice of medicine, documented accountability has been a prominent feature of volunteer efforts on

behalf of a common interest to protect the public well being. Accountability is used in this sense therefore as the documented observance of standards that are prescribed voluntarily by subscription to standards and rules set by professional organizations and prescribed by governmental statute and regulations (local, state, national).

The thrust of this review is to illustrate that from a historical perspective various voluntary professional agencies, societies, and organizations have accrued a defined responsibility for accountability of education and evaluation of performance within the health professions. As explained by Holden in 1974, their authority is delegated either formally or tacitly by the profession or legislation.^{4/} Their responsibility is clearly to ensure the meeting of prescribed standards and "to assure the public of the competence of physicians."

III. NHCS Relationships

Public interest, governmental interests (Congress and Department of HEW) and public interest groups (Nader, etc.,) have been increasingly stimulated by growing concerns over three basic issues related to health care:

1. Cost of care
2. Availability of care
3. Quality of care

^{4/} William D. Holden, In JAMA, p. 411, Vol. 230, 21 Oct 1974.

The controlling interests of both civilian voluntary authorities and statutory authorities have not ignored the same issues which affect the Navy Health Care System. This is not altogether surprising since the Medical Department represents an organized health care entity of certain visibility both within the Department of the Navy and within the country at large. Furthermore, the principles of health care and its products whether of civilian or Navy origin evolve from a mixture of nationally constituted interests in the welfare of the public. Just as the public has an overall interest in the Department of the Navy's accountability in ensuring the security of the nation's people with an effective naval force, it also has a demanding interest in the proficiency, efficiency, and economy with which Navy health care is delivered.

A review of the principal voluntary civilian agencies and organizations of medical interest alone reveals that there are some 190 whose names are published regularly in the Journal of American Medical Association. If all other organizations, societies, and agencies of somewhat less than national interest are added to this list, a completely unmanageable array of external relationships would prevail. Obviously, not all these bodies and groups have a significant degree of influence upon the NHCS. However, it is instructive to appreciate the magnitude of these groups. Of principal interest to the NHCS are the

following organizations:

1. JCAH - Joint Commission for Accreditation of Hospitals
2. AMA - American Medical Association
 - a. Committees
 - b. Councils
3. NBME - National Board of Medical Examiners
4. AOA - American Osteopathic Association
5. State Federation of Medical Boards
6. ANA - American Nurses Association
7. AHA - American Hospital Association
8. AAMC - Association of Medical Colleges
9. ABMS - American Board of Medical Specialties
10. All major professional societies such as:
 - a. ACP - American College of Physicians
 - b. ACS - American College of Surgeons
 - c. ACC - American College of Cardiology
 - d. AAFP - American Academy of Family Practice
 - e. ASA - American Society of Anesthesiologists
 - f. ASCP - American Society of Clinical Pathology
 - g. ACR - American College of Radiology
 - h. AAP - American Academy of Pediatrics
 - i. AAO - Academy of Ophthalmology and Otology
 - j. etc.
11. American Cancer Society
12. Blue Cross/Blue Shield Association

13. Mutual of Omaha
14. AMSA - American Medical Student Association
15. NMA - National Medical Association
16. ADA - American Dental Association
17. NIRMP - National Intern Resident Matching Plan
18. State Licensure Boards
19. PAS - Professional Activities Association
20. State Legislatures
21. Universities, Colleges, Schools of the Health Professions

The impacts of most organizations and agencies can be summarized in a matrix (Table A-1) which displays NCHS/voluntary organization relationships. By comparing the principal purposes with some selected organizations a visual grasp is more readily apparent. The broad purposes can be categorized as:

1. Educational
2. Standards setting
3. Regulatory setting and disciplinary
4. Statutory setting
5. Competency examination

NHCS RELATIONSHIPS

	Education	Standards	Competency Exams	Discipl. & Regulatory	Statutory
National Agencies					
JCAH		X		X	
NBME			X		
AMA	X	X		X	
AOA	X	X		X	
Major Prof. Societies	X	X	X	X	
Blue Cross/Ins. Co. etc.				X=rate/setting	
Specialty Boards	X	X	X	X	
State & Regional Agencies					
State Legislatures		X			X
Regional Prof. Societies	X	X		X	
Universities, Colleges, Schools	X	X			X
State Boards		X	X	X	X
Local & Community Groups					
County Societies	X	X		X	
Local Prof. Societies	X				
Educat. Institutions	X	X			X

Table A-1

For each of the boxes checked, there is a tangible impact upon the NHCS and its operation. The plurality and extent of interests are such that withdrawal of Navy Medical Department interaction and interface with recognized public welfare and health concerns would infer callous disavowal of the interests of the public and the nation at large.

In many of the interfaces, selected representatives of the Navy Medical Department have a direct voice and thus responsibility for expressing the interests of the Navy

within non-Federal organizations. For example, in the next table, the nature of medical department representation is reflected in some of the selected organizations.

	Voting Representa- tion	Committee Membership	Advisory Representa- tion
AMA	X		X
AHA	X	X	X
NBME	X		
Profess. Societies	X	X	X
JCAH			X

Table A-2

The distinct advantage to be gained by the Naval service is the maintenance of a responsible medical department voice in the proceedings of a non-Federal organization such that the health interests of the populace served by the NHCS will be preserved. Further, it provides a national forum for the explicit enhancement of the prestige and purpose of Naval service. Not to be excluded are the advantages gained from open communication, sharing of advances in health technology, performance comparisons, and standards surveillance.

IV. Obligations

As the NHCS has an obligation to provide adequate and appropriate health care to its entitled beneficiaries, it also has an obligation to provide health care according to the reasonable postulates and standards set within and by the nationally recognized representative organizations, bodies, and agencies. Albeit, this obligation fosters

a somewhat greater demand for resources than were the obligations absent. A quantified analysis of the monetary differences involved exceeds the scope of this review and will not be addressed.

Aside from the obligations associated with voluntary adherence to national organization and agency guidelines, there is a more compelling requirement which has not yet been addressed in this paper. A legal requirement to provide adequate and appropriate care in accordance with national recognized standards of due care and diligence serves as a strong impetus to proper fulfillment of health care responsibilities. Prior to 1946 and the passage of the Federal Tort Claims Act, governmental hospitals (Naval hospitals) were granted immunity from ordinary remedial legal redress. This Act served to partially waive the sovereign immunity of the federal government and thus Navy provided health care. Furthermore, in *Feres vs. United States* the Supreme Court provided the opportunity for injured persons to obtain the same legal remedies commonly available throughout the nation. In general, according to the Health Law Center^{5/}, suits brought under the Act are considered under the laws of the state where the negligence occurred. However, active duty members cannot make recoveries under the Act. This overall legal

^{5/} Health Law Center. Problems in Health Law, Aspen Systems Corporation, Rockville, MD.

influence helps to clarify the magnitude of the sense of responsible obligations attributable to Navy health care providers. In this light NHCS relationships with civilian organizations become clearly advantageous.

7. A Graphic Systems Model

The influences registered upon the management and administration of the NHCS by both implicit and explicit constraints which operate nationally can be conceptually portrayed. The depiction of regulatory influences of the voluntary national populace organizations is reflected in Figure A-1 by the heavy black line which boxes the Legislative, Executive, and Judiciary. This heavy baseline crosses the bi-directional arrows connecting the Federal regulatory segments with the monitoring and evaluation segment of the Navy Health Care System. Thus since the influences of the civilian voluntary regulatory organizations are extensive, multi-dimensional and national in scope, these same influences necessarily affect Navy health care inputs, outputs, and activities. The overriding reality is paramount and unavoidable.

VI. Forecast

Since the variability of the depth and extent of provision of health care in the nation at large reflects directly the expression of societal demand and health care capabilities, forecasting unto itself is a variable predictor and unreliable. However, the articulations by

NAVY HEALTH CARE SYSTEM

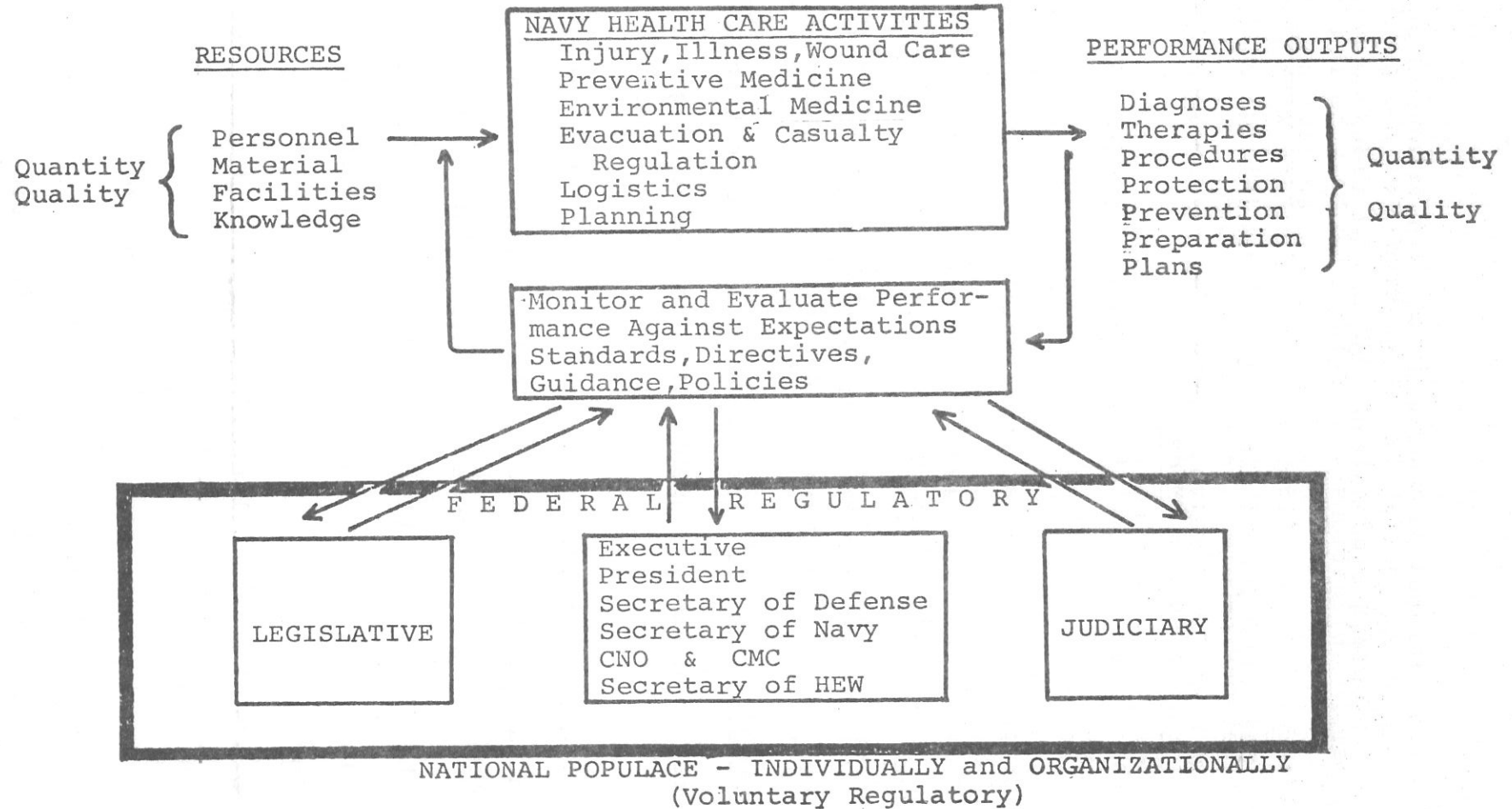


FIGURE A-1 Model of Functional Relationships

principal voluntary civilian organizations, bodies and agencies will no doubt increase as they increasingly attempt to resolve the major health issues confronting the nation today. Exclusion of the NHCS from participatory relationships in matters of health care on behalf of under 3,000,000 Americans would be unthinkable.

Forecasts which exclude consideration of the impact of Federal statutory developments are understandably valueless. The scope of Federal incursions upon the delivery of health care is most strongly demonstrated in one recent major impact, a summary of which is appended for review. Appendix E provides a summary of the recently enacted National Health Planning And Resources Development Act of 1974. Appreciation of this Act will partially indicate the extent of the far reaching national impacts which will no doubt influence the objectives and activities of voluntary organizations, bodies, and agencies, and not the least, the NHCS.

VII. Alternatives

The NHCS objectives, activities, and outputs are undoubtedly influenced by national statutory developments and by voluntary organization regulatory impacts. Accountability for the provision of satisfactory, adequate, and appropriate health care is a matter of national public and legal interest and thusly is not limited exclusively to Navy interests alone. Alternatives which exclude and

do not recognize national health care regulatory structures are non-workable in the Navy Health Care System.

VIII. Conclusions

The initial Navy Health Care Review Committee (NHCRC) approach to the overall review recognized the need to examine and explore the area of civilian influences and relationships. The functional impacts are complex, manifold, multi-dimensional, and professionally unavoidable. The principal benefits to the Navy are in terms of accountability, surveillance, adequacy of care, and competency of health providers. This review concludes that inherent advantages outweigh the disadvantages. However, in order to maximize benefits and limit to the best degree possible the disadvantages, formally constituted BUMED management controls are needed.

IX. Recommendation

CHBUMED formulate more explicit criteria and guidelines whereby NHCS/civilian interrelationships, objectives, functions, and expected benefits are clearly delineated and evaluated.

APPENDIX E

1. Summary of National Health Planning And Resources Development Act of 1974 (PL93-641).

SECTION B

NHCRC REVIEW OF THE NATURE AND IMPACT OF NON-NAVY FEDERAL INFLUENCES AND RELATIONSHIPS UPON THE NHCS

I. Introduction

The Department of the Navy strives to fulfill and conduct its managerial and operational missions within extensive manifestations of formal and informal organizational controls and constraints. As a military service, the Navy is subject to innumerable major forces, influences, and relationships. It works within a framework of almost incomprehensibly complex federal interfaces and resultant impacts upon the fabric of our nation. The magnitude and scope of the nature and impact of federal influences and relationships upon the Navy at large is both considerable and almost indefinable.

As a uniformed body integral to the Department of the Navy, the Navy Medical Department also operates within both formal and informal lines of federal authority, guidance, policy, and expectations. They impinge upon both the management and provision of health care support services. The impacts of these Federal influences and relationships on the NHCS are also considerable, but the effects on this small component of the Navy are more easily definable.

As a component of the Navy, the Navy Health Care System strives to provide health care support to a worldwide

dispersed population. As elsewhere defined in this review, the categorical areas of health care support are:

- Category I - Illness, Injury, Wound Care
- Category II - Preventive and Environmental Medicine
- Category III - Health Care Planning
- Category IV - Health Care Logistics

These four categories of support are broadly provided under four separately defined requirements for responsiveness listed as:

- Peacetime, non-deployed
- Peacetime, deployed
- Contingencies, non-combat
- Contingencies, combat

II. Discussion

A. General

The conceptual model of functional relationship developed in Section A applies in this discussion. The federal regulatory branches are separately labeled in Figure B-1 as Legislative, Executive, and Judiciary. Regarding influences of the latter, the impact of the Judiciary has been sufficiently discussed in Section A. External to the Navy, the principal sources of Federal impact derive from the Congress, its committees, and agencies and from the Executive, its departments, and agencies. An explicit purpose of most federal influences

NAVY HEALTH CARE SYSTEM

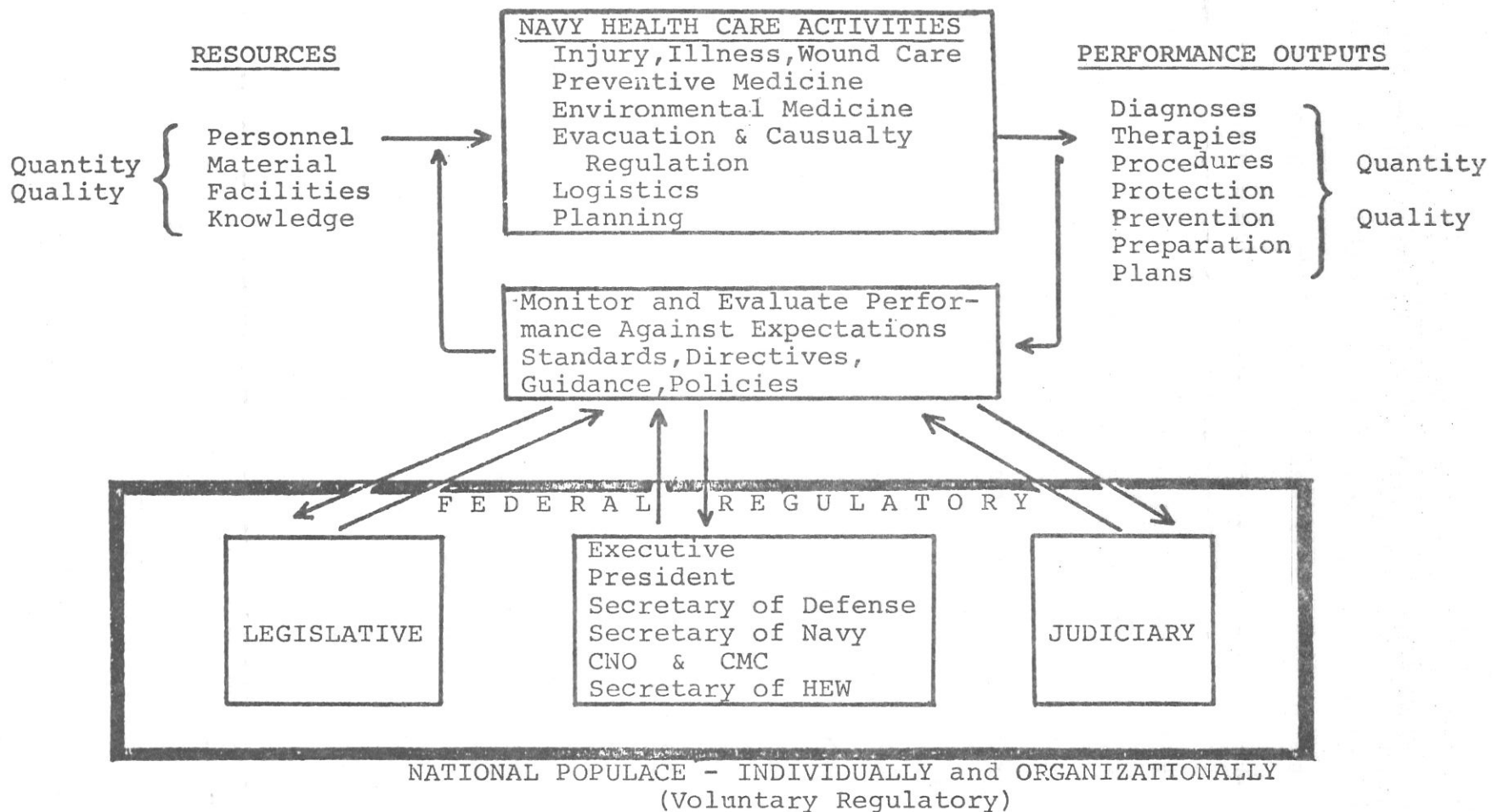


Figure B-1

MODEL OF FUNCTIONAL RELATIONSHIPS

and relationships is to assure responsibility and accountability in expending public money for national needs.

Thus the majority of the influences and relationships are:

1. Statutory and Regulatory
2. Authorization and Appropriation
3. Oversight and Surveillance
4. Evaluation and Review
5. Policy and Direction
6. Guidance and Interpretation
7. Determination and Allocation
8. Liaison and Cooperation

These federal influences impact greatly upon the NHCS, often result in conflicting demands, and wax and wane with the dynamics of political realities and national priorities.

B. Specific

Federal influences external to Navy impact upon the structure, processes, and outputs of NHCS functions and activities. Furthermore such federal forces both constrain and influence latitudes of health care operation, organizational expression, resource allocations, resource utilization, and functional coordination. Though the forces act in multiple and complex ways, greater understanding stems from organizing the federal bodies into groups deemed to have principal impacts upon the NHCS as follows:

1. Congress: (Influences/Relationships)

- Statutes and Regulations
- Authorization and Appropriations
- Evaluation and Review
- Oversight and Surveillance
- House Armed Services Committee
- Senate Armed Services Committee
- House Appropriations Committee
- Senate Appropriations Committee
- Congressional Budget Office (Emerging)
- General Accounting Office

2. Executive, non-defense: (Influences/Relationships)

- Authorization
- Regulation
- Evaluation and Review
- Policy and Direction
- Guidance and Interpretation
- Liaison and Cooperation
- Office of Management and Budget (OMB)
- Health, Education and Welfare (HEW)
- Public Health Service (PHS)
- Environmental Protection Agency (EPA)
- Veterans Administration
- Department of Labor - general and OSHA
- Department of State

3. Executive, defense: (Influences/Relationships)

- Authorization
- Regulation
- Determination and Allocation
- Department of Defense - general (OSD)
- OSD - Comptroller
- OSD - ASD(H&E)

- Evaluation and Review
- Policy and Direction
- Guidance and Interpretation
- Liaison and Cooperation
- OSD - ASD(I&L)
- OSD - ASD(PA&E)
- OSD - Uniformed Services University of the Health Sciences (USUHS)
- Army - Medical Department
- Air Force - Medical Department

C. Examples of Influences and Relationships

1. Congress:

a. The Armed Services Committees exercise control by authorization of programs, facilities, construction and training loads. They provide project and program approval, commission project and program studies, and assess project and program scope.

b. The Appropriations Committees perform similar functions with the added primary impact of budget approval and disapproval. Budget reductions have become commonplace events in recent fiscal years. Guidance is directed mostly toward ASD(H&E) vice the CNO and Surgeon General, Navy.

c. The now undetermined influence of the Congressional Budget Office as a newly established unit will be most likely felt in the upcoming FY 77 budget cycle.

d. GAO as the audit arm of Congress reviews, surveys, investigates, and analyzes selected medical department programs and activities. The impact is considerable

and their inquiries generally consume numerous manhours of response time. At last count there are an estimated 60 relevant GAO studies in progress.

2. Executive, non-defense:

a. OMB has in recent years delved deeply into review of professional health care issues, organization, activities, and functions in addition to budgetary review. Their analytic reviews are ostensibly conducted in coordination with OSD counterparts. Accordingly, review decisions are published and signed by the OSD official. Evident contradictions of Administration executive policy beget uncertainty in direction. For example, national health policy has focused on priority support for physician's extenders yet OMB has determined that the services will not conduct physician's assistants training programs. Also the OMB/OSD budget reviews are conducted without a formally published explicit statement of policy, direction, objectives, and criteria. Awaiting publication is the final report of the OMB chartered and chaired study of the Military Health Care System. One prediction of anticipated implications forthcoming from this study is expanded pre-occupation with the processes of management at the expense of preferred outcome of health care services.

b. HEW and its many branches and divisions has national responsibility in many areas dealing with health. They influence sources of health manpower,

organizational issues of health care delivery, financing of care services, and regulatory direction of quality standards of care. The Public Health Service provides care to Navy dependents upon demand. A significant relationship exists at New Orleans. Upon the opening of Naval Hospital, New Orleans the patient load at PHS Hospital, New Orleans will decline. On the other hand the Coast Guard recently has directed their beneficiaries to utilize PHS facilities vice DOD facilities. The inherent problem is fragmented coordination. As a division of the PHS, the Center for Disease Control (CDC) in Atlanta, Georgia, deals with surveillance and control of acute and chronic infections and non-infectious diseases. It provides diverse training courses, establishes quarantine policy, advises on immunization practices, and provides policy guidance and administrative management to the National Institute for Occupational Safety and Health. Thus the Navy interfaces directly with the CDC in virtually all preventive medicine matters. Within HEW, the Bureau of Radiological Health establishes and enforces national radiologic standards. For example, compliance with required surveys of X-ray equipment have necessitated unprogrammed training and funding expenses.

c. The EPA publishes standards regarding potable water quality, sewage and refuse disposal, product licensing of pesticides and disinfectants, and air quality. The Navy Medical Department interfaces directly with EPA in

the area of comment or proposed standards and compliance with applicable regulations. Compliance with EPA standards impact the NHCS with workload changes, increases in trained personnel requirements, and projected funding increments.

d. Aside from the obvious interface of patient disposition and care between the Navy and the VA, there are many other relationships. The VA as a user of the Federal Catalog Procurement System exercises strong influence on the medical supply field. In a different area of interest, during the upcoming Congressional review of military physician variable incentive pay the review will consider all federal physician incentives as an aggregate.

e. The Department of Labor, Occupational Safety and Health Administration (OSHA), impacts and relates directly with the Medical Department. CHBUMED provides the industrial hygiene program for the Navy. OSHA health standards rely on industrial hygiene capabilities to identify and quantify personnel exposure to various contaminants and pollutants. Implementation of the OSHA health standards is codified in the following.

- Occupational Safety and Health Act, 1970
- Executive Order 11807
- Code of Federal Regulations, title 29
part 1960 (includes non-civilians)

Implementation of the burgeoning federal mandates will mean maintenance of records, purchase of technology, and development of trained personnel, all unprogrammed resource increments. Current OSHA standards pertain to only 15 chemicals, a fraction of the health standards OSHA will eventually promulgate. The inherent problem relates to the uncertainty of available resource increments.

f. The Department of State impacts upon the Navy HCS with requirements for overseas interservice support agreements, performance of certain civilian payroll functions overseas, and through Administration foreign policy commitments and programs (i.e., New Life, Nimbus Star, etc.).

3. Executive, defense:

a. OSD establishes and determines Department of Defense program policies and priorities primarily via planning, programming, and budgetary guidance. Primary responsibilities for performing these functions are vested in diverse defense offices.

b. The OSD Comptroller works through the NAVCOMPT/CNO chain. The primary influences are exerted annually through the budget review and Program Budget Decision process. At other times in a given budget year, comptroller actions involve budgetary deferrals and adjustments. OSD reviews budgetary requirements for OPN investment equipment. OSD also determines general

accounting policy, eligibility for treatment, and recently set goals for reduction of length of hospital stay rates.

c. The ASD(H&E) office has expanded both its staff and scope of responsibilities in recent years. Frequently its members demand information and data directly from offices in BUMED external to the recognized chain in the formal organization. Bypassing OPNAV/NAVCOMPT impedes the desirable advantages of orderly and informative communications. House Appropriations Committee actions have directed establishment of increasing direct authority within ASD(H&E) with concomitant loss within SECNAV resulting in further reduced decision latitude by CNO. Incorporation of CHAMPUS management within ASD(H&E) has fragmented coordination and responsibility. The trend toward absorption of further individual service health care direct responsibilities is reflected in the move to assume managerial control of allocated resources related to paying for care of AcDu personnel who are patients in civilian health facilities.

d. ASD(I&L) controls the Defense Supply System and interacts with other federal agencies on matters of installations and logistics. The Medical Department interface is through COMNAVFACENGCOM. ASD(I&L) provides project design criteria, project approval, and establishes fiscal limitations with issuance of Program Budget Decisions.

e. ASD(PA&E) and ASD(M&RA) influences have been visible recently in a spectrum of issues affecting the Navy

HCS. Representatives from these offices are members of the Steering Committee of the OMB chaired Military Health Study. These offices have reviewed recent individual service medical contingency studies. They participated in the 1974 implementation of the VIP legislation for military physicians.

f. Army and Air Force medical departments impact heavily upon the NHCS. Both force and policy changes influence NHCS policies and delivery of health care. Unilateral Army or Air Force withdrawal of medical support in an area can result in unprogrammed and unfunded new requirements for the Navy Medical Department. Army facility construction policies have significantly influenced Navy planning in certain geographic areas. Coordinating relationships have evolved to an unprecedented degree with formal tri-service agreements, committees, and consolidations; selected few examples.

- Defense Medical Material Board (DMMB)
- Tri-Service Management Information System (TRIMIS)
- Interservice Training Review Organization (ITRO)
- Common AcDu Training Obligations
- Uniformed Services University of the Health Science (USUHS)
- Armed Forces Epidemiological Board (AFEB)
- Armed Forces Pest Control Board
- Interagency Radiation Health Group
- Tri-Service Regional Area Designation

g. Joint and Unified Command influences entail an explicit and implicit scope and intensity related to the tasks assigned the three Services (Army, Navy, and Air Force) by unified commanders. These tasks significantly impact upon the Services' allocation of medical resources and the distribution of funds. In operational mission relationships the unified commanders develop the operations plan based principally upon component Services operations plans submissions. Conduct of the operation authorized by operational command is the responsibility of the unified commander. He in turn is directly responsible to SECDEF as advised by the Joint Chiefs of Staff. Provision of required medical and dental resources (logistics within the unified commander's directive authority) are the responsibility of the Services with joint Service coordination by the unified commander. Capabilities and requirements shortfalls are a Service responsibility to correct or accept. Thus unified commander task assignments influence Navy health care support.

III. Findings/Problems/Forecasts

Pervasive external federal influences and relationships affect the Navy Medical Department and consequently the Navy Health Care System. The visible trends are:

- Increasing consolidation of support services.
- Increasing tri-service cooperation.
- Increasing tri-service commonality.

- Increasing policy level interest in issues of management.
- Increasing adoption of field level responsibility at higher levels of management.
- Increasing centralization of managerial controls.
- Increasing requirements for standards compliance.
- Increasing planning uncertainties.
- Increasing surveys, audits, and evaluations.

These trends constitute the most likely reliable predictor for both future short and mid-range periods. There is no indication of trend line leveling. To the contrary, expectations should be directed toward continued intense activity in each of the listed trends and those unlisted.

A potential influence and impact not yet fully discussed deals with the matter of National Health Insurance (NHI) legislation. As an unresolved issue still under committee consideration in both the House of Representatives and the Senate, and in face of Administration preference to limit new federal spending, the likelihood is poor for immediate forthcoming passage of a comprehensive bill. Eventual passage of an NHI instrument is almost inevitable within 2 to 5 years. The impact will no doubt affect the Naval populace and beneficiaries with resultant substantial changes in the character, quality, and cost of Navy health

care support. The degree and rating of impact requires serious evaluation, study, and planning to assure continuance of adequate and appropriate health care support for Navy beneficiaries entitled to health care benefits.

IV. Conclusions

Congressional and Executive influences will continue to impact heavily upon Navy health care support in the out-years. Centralized management and extensive consolidations of tri-service health services (or potentially single health services) is possible. In absence of valid planning decisions, accurate prediction of the future character of Navy health care support is difficult.

V. Recommendation

CNO, CMC and SGN direct an in-depth staff assessment of all pertinent current information pertaining to the evolution of further centralized health care management and consolidation and pertaining to the uncertain implications of NHI legislation. Assessment of alternatives and forthcoming suggested decisions and positions should assure the continuance of adequate, appropriate and responsive levels of health care support for, at least, all ACDC personnel under the conditions of the four separately defined health care support requirement categories.

SECTION IV

Navy Health Care Organization

Section A - Overview of the Organization of the Navy
Health Care System

Section B - NHCRC Review of Organization and Status
of Naval Medical and Dental Regionalization
Program

SECTION A

OVERVIEW OF THE ORGANIZATION OF THE NAVY HEALTH CARE SYSTEM

I. Introduction

A. This section briefly describes the relationship of the Bureau of Medicine and Surgery/Surgeon General, Department of the Navy, to those activities and/or elements of the Navy Medical Department which are described as BUMED managed or non-BUMED managed. For a detailed organizational description, the reader is referred to publications such as the Organization Manual, Bureau of Medicine and Surgery, Department of the Navy (BUMEDINST 5430.4A) and the Navy Support and Mobilization Plan (NSMP), Part 2, SECTION XIII, classified SECRET.

B. The thrust of the discussion which follows is centered upon the methods by which the Surgeon General carries-out the missions of: (1) the Navy Medical Department and, (2) the Bureau of Medicine and Surgery, i.e., respectively: (1) to safeguard and promote the health of the Naval Forces (which includes all Marine Corps Forces) to assure combat readiness and promote care and treatment to persons as authorized, and (2) to plan, develop, program, and direct a "Health Care System" in support of the Navy Medical Department's mission;

to develop and institute policy and standards of professional practice, training and research, and provide effective management of resources.

C. The implications of the organizational relationships have a distinct bearing upon the delivery of health care in the Navy and the management of Navy Health Care resources.

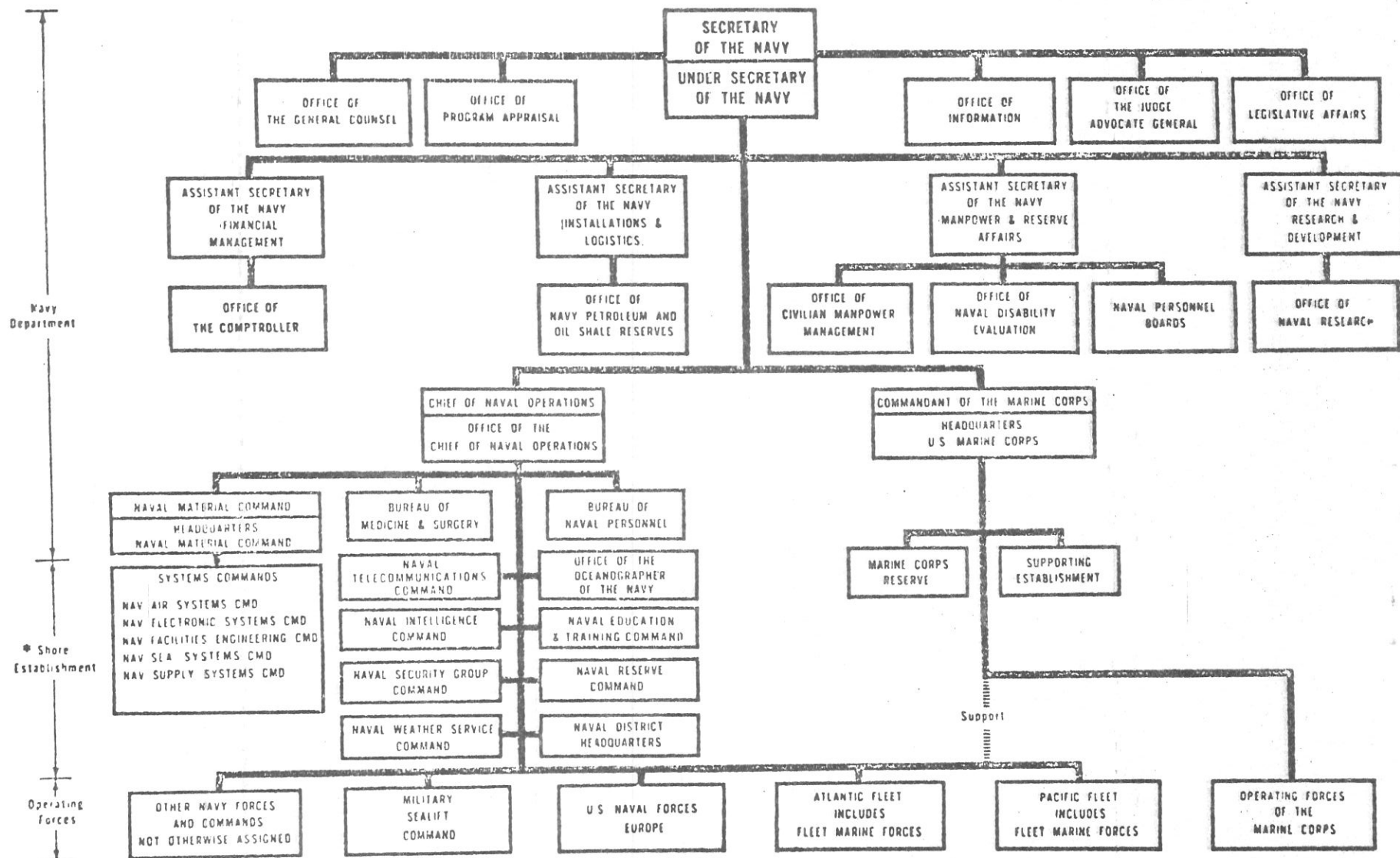
II. Discussion

A. Departmental Command Relationships:

Under the command of the Chief of Naval Operations, the Chief, Bureau of Medicine and Surgery (who is also the Surgeon General of the Navy) commands the Bureau of Medicine and Surgery and those shore activities as assigned by the Chief of Naval Operations. The relationship of the Bureau of Medicine and Surgery to the Secretary of the Navy and the Chief of Naval Operations is depicted by Figure A-1. The roles of the Chief of Naval Operations and subsequent position of the Chief, Bureau of Medicine and Surgery, BUMED, and BUMED assigned shore activities is depicted by Figure A-2 (they also depict the position of the Commandant of the Marine Corps and his relationship to the Secretary of the Navy as well as the Chief of Naval Operations).

B. Field-Level Command Assignment:

All elements of the Navy's "Health Care System" referred to above are not under the direct command of



* Also Includes Other Designated Shore Activities Not Shown On The Chart
Which Are Under The Command Or Supervision Of Many Of The Organizations Depicted

FIGURE A-1
NAVY DEPARTMENT COMMAND RELATIONSHIPS

THE ROLES OF THE CHIEF OF NAVAL OPERATIONS

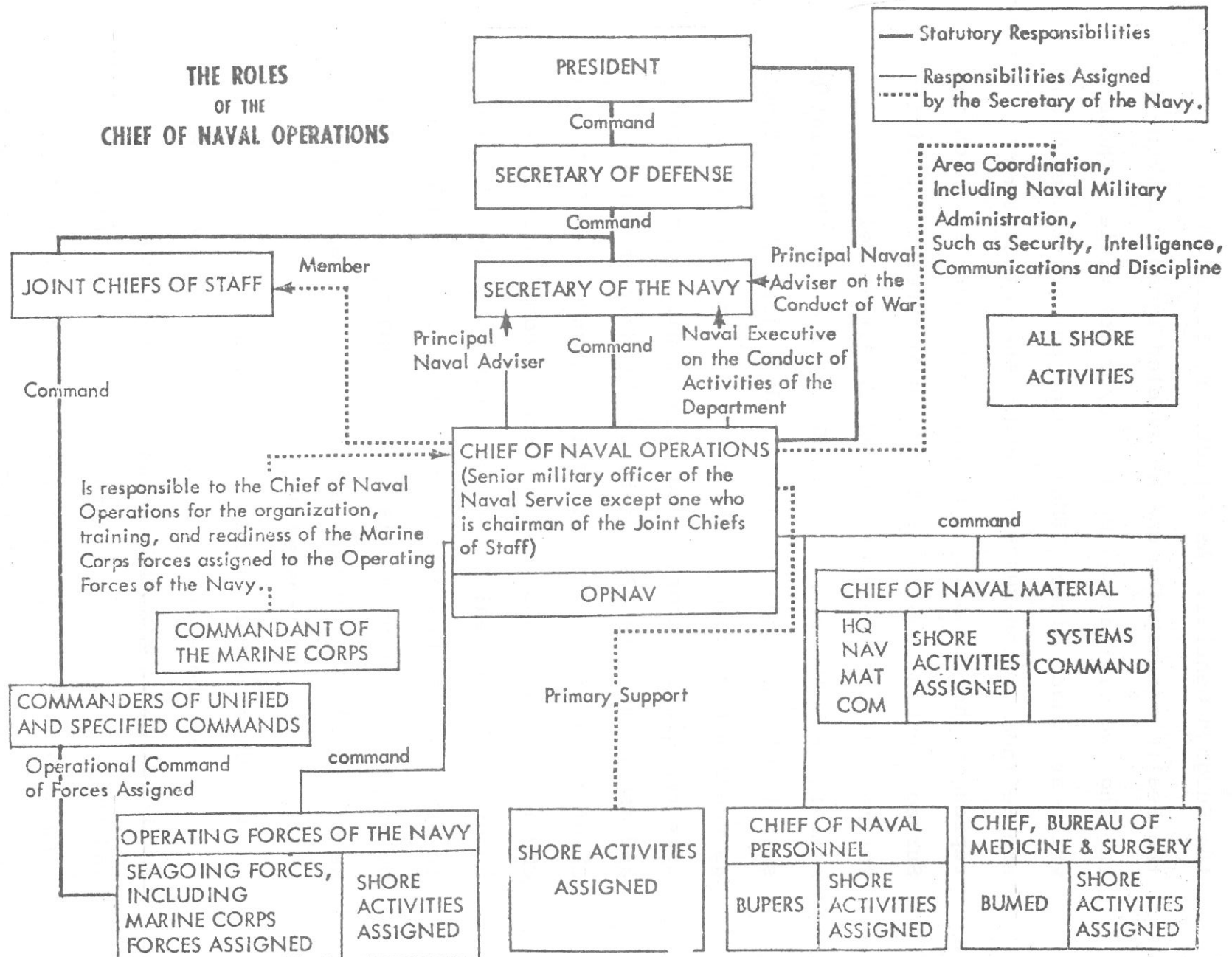


FIGURE A-2

the Surgeon General. As depicted by Figure A-3, the health care system can be modeled broadly as containing two distinct elements and/or activities; those which are under direct BUMED management and those which are defined as non-BUMED managed. The solid lines represent the authority (command) structure in which the Surgeon General has command and support responsibilities for medical treatment or medical treatment related activities. The broken lines depict broadly the relationship leading to those elements and/or activities defined as non-BUMED managed in which the Surgeon General has only technical authority and responsibility as defined and assigned by the Secretary of the Navy and/or the Chief of Naval Operations. This assignment by SECNAV or CNO is dependent upon the particular command cognizance under which the health care delivery is to be provided. In other words, CNO assignment for activities (Navy and/or Marine Corps) under his direct command and SECNAV assignment for activities not under the direct command of CNO (example: shore-based Marine Corps units).

C. Chief BUMED Command Responsibilities:

For those elements within the health care delivery which are defined as BUMED managed, the normal command and support authority exists; the Surgeon General has responsibility for providing medical and dental care services to authorized persons, planning and programming

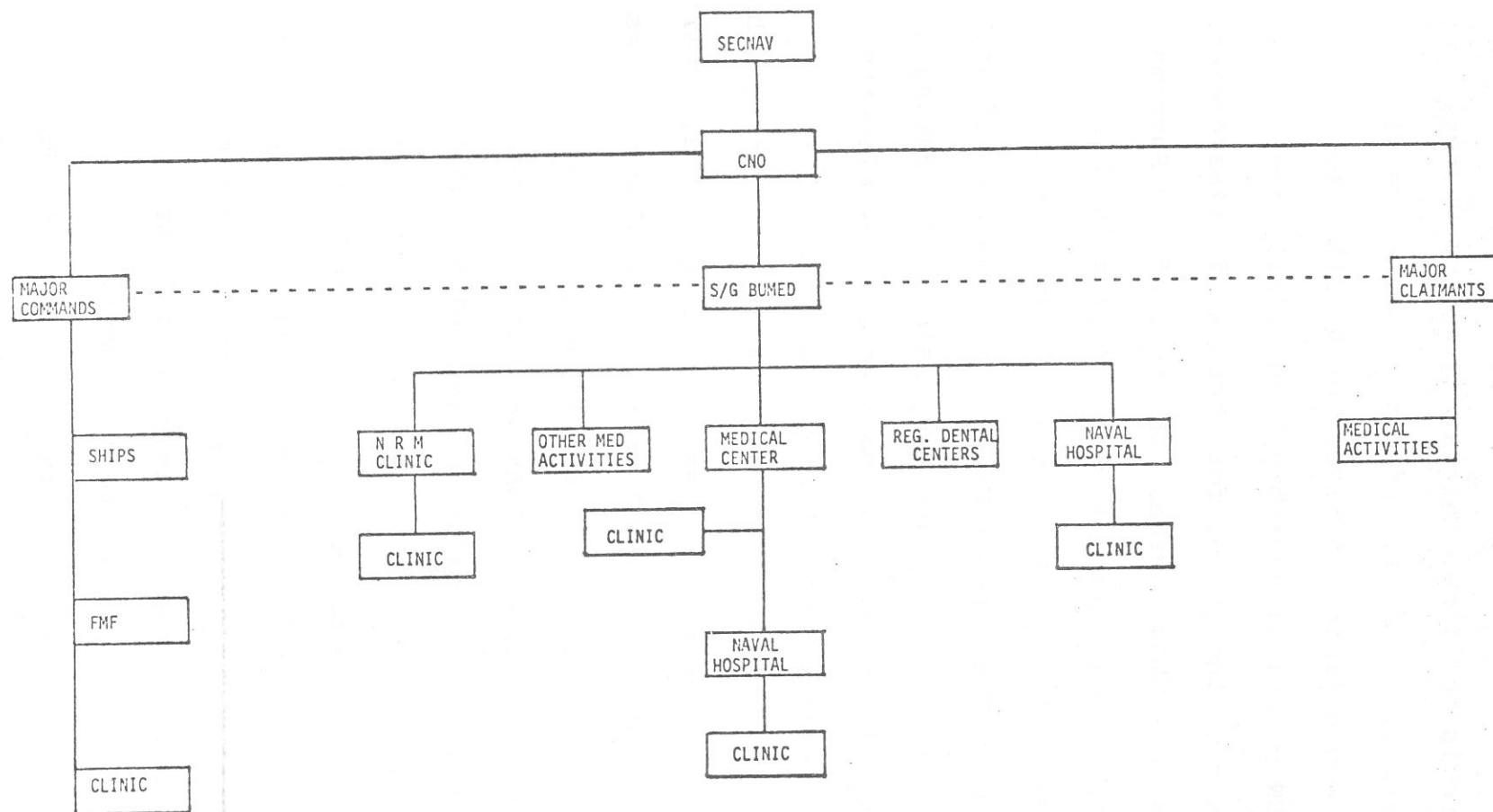


FIGURE A-3
CHBUMED/SURGEON GENERAL'S RELATIONSHIP
WITH NAVY HEALTH CARE FACILITIES

health related policy and directives, conducting appropriate inspections, initiating and conducting research and development, and ensuring the overall effective and efficient delivery of health care.

D. SGN Technical Advisory Responsibilities:

On the other hand, for those activities/elements defined as non-BUMED managed, the role of the Surgeon General may be best described as one of a "technical advisor." In this role, the Surgeon General (directed by SECNAV and/or CNO as described above) has only technical authority and responsibility. Having no direct command authority in these activities/elements of the Navy's Health Care System, the Surgeon General (as Chief of the Navy Medical Department) nevertheless has responsibility for the professional and technical supervision of medical and dental matters. He also provides professional and technical advice and assistance to the numerous commands under SECNAV (example: Commandant of the Marine Corps) and/or CNO (examples: Naval Material Command, systems commands, Bureau of Naval Personnel, Fleets, commands to include Naval and Marine Corps forces; and other offices, commands, or agencies which utilize medical/dental manpower, facilities, equipment, and material requisite to full health care support for the Department of the Navy).

The relationships between the Surgeon General and those activities/elements described as non-BUMED

managed are complex, since many lines of commands are transversed and the Health Care System itself is, as a whole, complex.

E. Navy Health Care Delivery Organization:

As discussed in Vol. I, Section V a continuum of patient care exists in the Navy health care delivery system which seeks to decentralize the less specialized and less expensive primary care, and centralize the more costly and more specialized secondary and tertiary care. In this continuum of care, the patient receives care at the institution nearest to him which is capable of handling his medical problem, but regardless of where he initiates contact with the system, he must have access, commensurate with his medical care needs, to the entire spectrum of primary, secondary, and tertiary services provided within the system.

The three levels of health care services require different mixes of provider skills, equipment and facilities support. However, none of the three levels of services can stand alone. Only when the three levels are integrated into a continuum of care does the active duty individual have the comprehensive range of personal health care services to which he is entitled by law.

The presence of primary, secondary, and tertiary services does not in itself guarantee the necessary continuum of care. A smooth continuum of care is present only when the patient referral patterns are well

established such that the individual can be moved smoothly and quickly from his entry point in the system through to the most specialized tertiary care if his case warrants it.

III. Implications

A. Health Care Delivery:

The Navy's continuum of patient care encompasses all health care delivery facilities regardless of whether they are BUMED managed or not. The professional health care complexities inherent in the larger, predominantly secondary and tertiary care facilities necessitate that their sophisticated capabilities be directly managed by the CHBUMED. The integration (with some few exceptions) of closely related primary care facilities ashore into a smoothly functioning continuum of care has been accomplished through the medical and dental regionalization programs. The operational orientation of the predominantly primary care capabilities organic to the operating forces necessitates that they remain under the operational control -- and therefore the management -- of their respective operational commanders. However, these organic health care capabilities are essential elements of the Navy health care delivery continuum. Thus, the continued policy guidance and influence implicit in the technical advisory role of the

Surgeon General must be the means by which these capabilities are integrated into the health care continuum which is the Navy Health Care System.

B. Health Care Resources:

Since the basic concept of "resources following command lines" is inherent in both sectors of the Navy Health Care System, the fixing and tracking of resource (money, manpower, supplies, facilities, etc.) responsibility, by the Surgeon General, is possible only under the BUMED managed segment. The same resource accountability at Non-BUMED managed segments of the model is not assigned to the Surgeon General nor to any other single management authority. Therefore, identification of all resources assigned to and expended by the Navy's Health Care System as a whole cannot be readily accomplished.

The concept of regionalization did much to assist in the overall accountability of shore-based medical resources (money, manpower, facilities, supplies, etc.) which are previously identified as non-BUMED managed, i.e., medical activities/elements assigned to non-BUMED commands which were shifted to BUMED command with subsequent total resource management. However, the diffusion of resource responsibilities within the two health care system segments still complicates total identification of resource accountability. In the absence of appropriately structured resource programming and accounting systems the actual

commitment of Navy resources to health care will remain incomplete subject to resource programming and accounting.

IV. Conclusions

A. The organization of the Navy Medical Department is structured upon logical lines of command authority. This organizational structure is at variance with the ideal organization of the Navy Health Care System which could be structured upon functional lines commensurate with the concept of a continuum of health care delivery.

B. The organizational variance is a necessary, optimal fact of life in a health care system which is a subordinate element of the Navy.

C. Close coordination of the non-BUMED managed segment of the Navy Medical Department by the Surgeon General is essential to ensure effective and efficient functioning of the health care delivery continuum and the entire Navy Health Care System.

D. Modification of the present resource programming and accounting systems will be required if the Navy desires to achieve complete identification and coordinated management of the total Navy health care resource commitment.

V. Recommendations

A. That the Surgeon General of the Navy give appropriate emphasis to technical advice to, and communication with, the non-BUMED managed elements of the Navy

Medical Department in order to optimize their essential contribution to the Navy Health Care System.

B. That OP-090 and BUMED explore ways to improve Navy health care resource programming and accounting (see further expansion of this recommendation in SECTION VII).

SECTION B.

NHCRC REVIEW OF ORGANIZATION AND STATUS OF NAVAL MEDICAL AND DENTAL REGIONALIZATION PROGRAM

I. Purpose

To provide a brief background of the Medical Department's evolution toward and current status of regionalization.

II. Findings/Discussion

Until 1971, the Navy health care system was fragmented and only minimally coordinated. Most Naval medical facilities were operated and managed as departments under command of non-BUMED major claimants and were essentially separate, autonomous medical entities. Nineteen non-medical major claimants commanded 197 medical facilities; CHBUMED commanded 45 medical facilities.

With the ultimate professional responsibility for the medical care provided in all Naval medical facilities and the obvious need for greater coordination, the CHBUMED implemented a pilot program in the Norfolk area in July 1971. This large concentration of 13 Naval medical facilities with its over 2,700 military and civilian health care personnel, were under eight separate commands, and provided an excellent testing ground for the theory of regionalization.

Within six months from establishment of the first Naval Regional Medical Center at Portsmouth, VA., approval of the concept was assured. On 4 February 1972, the CNO approved the Navy Medical Department plan for regionalization and phased implementation commenced. At the conclusion of the current phase (end of calendar year 1975) 173 naval medical facilities will be regionalized within 28 naval medical regions under command and support of BUMED. Thirteen non-BUMED medical facilities will not be regionalized due to base closure, shore establishment realignment, and other considerations.

Regionalization has resulted in changes of health care delivery and implementation of altered patterns in medical support operations. Shortages of certain medical specialty personnel and budgetary constraints have prevented regionalization from immediate attainment of its objectives. On the other hand, shifting command responsibility of local area medical facilities upon regionalization from line commanders to the CHBUMED chain of command has introduced a widespread feeling in some locations that the regionalized medical services are no longer responsive to operational force needs. The opinion that the regional medical center or hospital takes precedence over the fleet in utilization of steadily declining health care resources must be subjected to testing, verifying, and analyzing. Then reforms should be instituted in accordance with the facts.

In assignment of health care personnel to regionalized facilities, a limiting factor was introduced; i.e., the corporate limits proviso. This means a person assigned to a medical facility is restricted to performing services within the boundary of the corporate limits in which the medical facility is located. This regulation protects the individual from the hardships of being indiscriminately shuffled about within a medical region at distances generally too great to commute.

Assessment, analysis and evaluation of regionalization has been initiated as a formal BUMED project.

The Surgeon General in his opening remarks to the Medical Specialty Advisory Council on 9 September 1975 stated, "We must accelerate into a shortened time frame the filling of empty operational medical billets, both afloat and ashore," when addressing the Medical Department's problem requiring "top priority attention." He emphasized that, "medical support to the fleet is at the very heart of what Navy medicine is all about."

Regionalized medical centers and hospitals provide a base or source for immediate response to unanticipated operational requirements through use of augmentation teams and other personnel support.

Some of these same centers and hospitals provide a pool for assignment of medical officers to deploying

Within six months from establishment of the first Naval Regional Medical Center at Portsmouth, VA., approval of the concept was assured. On 4 February 1972, the CNO approved the Navy Medical Department plan for regionalization and phased implementation commenced. At the conclusion of the current phase (end of calendar year 1975) 173 naval medical facilities will be regionalized within 28 naval medical regions under command and support of BUMED. Thirteen non-BUMED medical facilities will not be regionalized due to base closure, shore establishment realignment, and other considerations.

Regionalization has resulted in changes of health care delivery and implementation of altered patterns in medical support operations. Shortages of certain medical specialty personnel and budgetary constraints have prevented regionalization from immediate attainment of its objectives. On the other hand, shifting command responsibility of local area medical facilities upon regionalization from line commanders to the CHBUMED chain of command has introduced a widespread feeling in some locations that the regionalized medical services are no longer responsive to operational force needs. The opinion that the regional medical center or hospital takes precedence over the fleet in utilization of steadily declining health care resources must be subjected to testing, verifying, and analyzing. Then reforms should be instituted in accordance with the facts.

In assignment of health care personnel to regionalized facilities, a limiting factor was introduced; i.e., the corporate limits proviso. This means a person assigned to a medical facility is restricted to performing services within the boundary of the corporate limits in which the medical facility is located. This regulation protects the individual from the hardships of being indiscriminately shuffled about within a medical region at distances generally too great to commute.

Assessment, analysis and evaluation of regionalization has been initiated as a formal BUMED project.

The Surgeon General in his opening remarks to the Medical Specialty Advisory Council on 9 September 1975 stated, "We must accelerate into a shortened time frame the filling of empty operational medical billets, both afloat and ashore," when addressing the Medical Department's problem requiring "top priority attention." He emphasized that, "medical support to the fleet is at the very heart of what Navy medicine is all about."

Regionalized medical centers and hospitals provide a base or source for immediate response to unanticipated operational requirements through use of augmentation teams and other personnel support.

Some of these same centers and hospitals provide a pool for assignment of medical officers to deploying

units while the current shortages of physicians assigned operational billets exists. This medical officer pool pilot concept is currently undergoing feasibility evaluation in both fleets.

III. Conclusions

Regionalization transferred funding responsibility for the hospitals and medical facilities from the local line commander to the BUMED chain of command. Fiscal management problems and less than sufficient funds plague these BUMED commands today as other communities of the Navy.

The impression held by some line commanders that regionalization has resulted in lack of responsiveness to operational requirements, based on real or exaggerated situations, must be corrected by managers of the Navy Health Care System.

Corporate limits rule does prohibit maximum flexibility and utilization of limited personnel assets in the larger regional medical centers.

Continually declining numbers of health care personnel, addressed elsewhere in this review, will by definition result in more limited services being provided by medical and dental regionalized facilities.

APPENDIX F

List of Naval Regional Dental Facilities

List of Naval Regional Medical Facilities

SECTION V

Health Care Support Functions

Section A - Health Care Support Functions: Patient Care

Section B - NHCRC Review of Definitions of the Essential Elements of Health Care Support for the Operating Forces

Section C - NHCRC Review of Navy Medical Department Personnel Augmentation to the Operational Forces

Section D - NHCRC Review of Medical Department Education and Training

Section E - NHCRC Review of Medical Research and Development

SECTION A

HEALTH CARE SUPPORT FUNCTIONS: PATIENT CARE

I. Introduction

This section briefly outlines a summary of many classifications developed throughout this review of the Navy Health Care System. Furthermore, it provides a discussion of two additional subjects: an arbitrary classification of the complexity of the range of patient care services and a functional explanation of the continuum of patient care. Summarization of the immediately relevant classifications developed during this review provides a useful orientation to dynamic patient care relationships in the Navy Health Care System.

II. Discussion

A. Summary of Classifications

Among the classifications developed throughout this review, those having a close relationship to patient care as a health care support function follow:

- Categorical Definitions of Health Care Support

Category I - Patient Care

Category II - Preventive and Environmental
Medicine and Dentistry

Category III - Health Care Planning

Category IV - Health Care Logistics

- Patient Care
 1. Peacetime, Patient Care
 - a. Illness
 - b. Injury
 - c. Wound Care
 2. Contingency, Types of Casualties
 - a. Wounded in Action
 - b. Disease and Non-Battle Injury
- Patient Care, Essential Components
 1. Emergency and Life Saving Care
 2. Routine Health Care
 3. Definitive Care in Theatre
 4. Definitive Care, Conus
- Patient Beneficiaries
 1. Active Duty
 2. Dependents of Active Duty
 3. Retired
 4. Dependents of Retired
 5. Others
- Navy Health Care Skill Orientations
 1. Naval Officer/Enlisted
 2. Navy Health Care Support Equivalent
 3. Civilian Health Care Support Equivalent
- Structural Components of Care
 1. Naval Medical Centers, Hospitals, Clinics

2. Fleet/Force Organic Medical Department
Activities, Units

3. Civilian Services, Out Service

● Types of Patient Care Services

1. Preventive

2. Diagnostic

3. Therapeutic

4. Maintenance

5. Ameliorative

6. Research

7. Medical and Dental Education

● Requirements for Responsiveness

1. Peacetime, non-deployed

2. Peacetime, deployed

3. Contingencies, non-combat

4. Contingencies, combat

● Patient Care Services, Complexity of Range

1. Primary

2. Secondary

3. Tertiary

B. Complexity of Range of Patient Care Services

In an effort to classify the complexity of the full range of patient care services, an arbitrary division of the entire spectrum of patient care services has emerged.

The terms commonly used by health care providers and users alike to differentiate varying levels of patient care consist of primary, secondary, and tertiary. These terms have been diversely and loosely used to describe patient care functions, capabilities, activities, services, providers, etc. Despite common usage, the descriptive terms of primary, secondary, and tertiary personal health care services suffer from a lack of finite consensus and definition. The absence of clear cut definitions of the terms primary, secondary, and tertiary patient care is undoubtedly a chronic source of sharp disagreement and misunderstanding.

Recognizing the need for a framework upon which to build an acceptable common understanding of these terms, the Committee acknowledged the general utility of arbitrarily subdividing the broad range of personal health services. Rather than discard the primary, secondary, and tertiary divisions, the Committee focused on a descriptive development of these terms. Delineation of exact meanings to serve as a doctrinal frame of reference was not intended. Instead characteristics of each of the levels were developed to serve as a basis for common understanding, continued discussion, and future clarification.

1. Primary patient care services involve an extensive range of care and services which are basic, central, and essential to the fulfillment of the medical department mission. As in all levels of health care services primary care is based upon a firm foundation which integrates applied knowledge of medical, biological, physical, social, psychological, and behavioral sciences. Thus primary care services have many objectives, including:

- initial patient entry, contact, assessment and evaluation
- care of sick and well principally in ambulatory settings
- attempts to solve as many patient problems as possible at the primary care level
- prevention of diseases, injuries, and environmental caused disorders
- health promotion through counseling, health education, and referral into other community resources
- coordination of health care training, personnel and services for optimal reduction of patient problems

- provision of psychological and emotional support
- assumption of responsibility for continued patient care and contact with patients
- responsibility for recognition and evaluation of patients' health needs including those that are both minor and serious
- provision of advice and services designed to promote optimal health maintenance and maximal patient capability to assume responsibility for personal care
- optimal and knowledgeable utilization of and referral into secondary and tertiary patient care levels
- assumption of patient care responsibility following maximal benefit divided from secondary and tertiary care.

The delivery of primary care services in the Navy may be provided by a variety of health professionals, singly or as a team, and in a variety of settings, organic to the fleet forces or in regional centers, hospitals, and clinics. Diverse as primary care is, the key components are ready, and reasonable access to responsive health care provided in a caring and supportive manner. Thus the independent duty hospital corpsman

provides primary care within the limits of his competence and capabilities to a shipboard population. Marine platoon and company corpsmen provide similar services. Medical officers provide primary care whether they be generalists, specialists, or military medical specialists. Dental officers invest substantial time in primary care. Both nurses and nurse practitioners participate in primary care. Medical Service Corps officers lend considerable assistance to the delivery of primary health care.

The delivery of primary care is not limited to sick bay and clinic settings alone. However, much directly delivered primary care is associated with outpatient and ambulatory patients. Of prime importance is the fact that primary care cannot stand independent of the other two levels any more than the latter can exclude dependence upon primary care. Practically speaking primary care is concerned with health conditions and variations from health which are of high frequency within populations and which require modest technical complexity.

2. Secondary patient care services constitute an intermediate level of complexity between primary care and tertiary care. Most commonly secondary care depends greatly upon extensive specialized

competencies and skills in addition to primary care practitioners, i.e. primary care specialists in general practice, internal medicine, family practice, pediatrics, and obstetrics/gynecology. Most secondary care services are associated with in-hospital care but this is by no means an exclusive characteristic since considerable outpatient and ambulatory care represents intermediate level complexity.

Health conditions of moderate frequency within populations and not requiring highly complicated levels of technique are most accurately described as falling within the secondary care level. Secondary care services are also well described as being virtually curative in nature as opposed to predominantly health maintenance and general preventive measures. Thus secondary care serves as the principal specialty dependent and hospital back up capability for primary care.

Most specialty medical officers and allied sciences officers perform their skills at this level owing to a dependence upon general or community-type hospital resources. Most common surgical and medical management is conducted at this level. The allied science practice of optometry and podiatry is predominantly a secondary care service. Dental practices of periodontics, prosthodontics, and endodontics is generally considered within

the level of secondary care. The setting for secondary care invariably consists of areas and facilities which provide a localization of intermediate skills and moderately expensive equipment concentrated or centrally based within a fixed health care facility. Within the Navy many secondary care services are provided in aircraft carrier medical wards, field hospitals, and specialty manned clinics. All shore-based hospitals and centers provide most general services at the secondary level. Hence, secondary health care services are concerned with illness, injury, and wounds which are of moderate frequency and which require moderate technical complexity.

3. Tertiary patient care services comprise the level of personal health care at the highest extent of complexity. The most complicated and specialized medical diagnostic and therapeutic services fall within this category. It includes the services of the super specialists and many of the subspecialists. The conditions requiring this level of service are not generally encountered with the frequency of most conditions found at primary and tertiary care levels. Among the services characteristic of this level are: complicated surgical and medical procedures to diagnose and treat cancer, high risk newborn and maternity care, certain brain

and spinal cord procedures, kidney transplantations, special blood component replacement, kidney dialysis, extensive restorative and rehabilitative procedures and supportive care, selected psychiatric care, computerized X-ray diagnosis capability, open heart surgical procedures, complicated radiation therapy, bone and joint replacement and complex reconstructive procedures, subspecialty dependent intensive care units, burn and extensive trauma service capabilities, elaborate laboratories and operating rooms, and other special care facilities.

Understandably this degree of complexity, sophistication, and advanced technology is also intensely labor dependent and highly advanced skill dependent. For that reason the arbitrary designation of tertiary care services is in the best interests of economy. Concentration of highly technical skills, equipment, and technology within specified facilities has obvious advantages since broad and unnecessary dispersion would strain any financial support beyond reason.

In the Navy tertiary care services are found primarily at the large regional medical centers such as Bethesda, San Diego, Portsmouth and Oakland. Characteristically a comprehensive spectrum of medical, dental,

and allied health specialists support tertiary care capabilities. Generally tertiary health care services are concerned with illness, injuries, wounds and disorders which are of low frequency compared with primary and secondary care and which require considerable technical complexity.

4. Primary, secondary, and tertiary care comprise artificial divisions on levels of complexity of care and may be used to indicate a type of health care facility. If used to describe a facility, a potential misunderstanding can arise - that is, that a tertiary care facility is limited solely to tertiary care. Within the Navy all tertiary care centers contribute to and function throughout the entire spectrum of health care complexity. Thus regional centers produce weighted workload outputs consistent with each level of complexity and no center performs tertiary care to the exclusion of secondary and primary care.

C. The Continuum of Patient Care

The artificial division of health care services requires different health professional skills, equipment and facilities support. However, none of the three levels of care can stand alone. Only where the three levels are available and coordinated in a continuum

of care does the active duty population have the comprehensive range of personal health care services to which they are entitled by law.

III. Organization and Management of the Continuum of Care

A. Problem

Three conditions pose a dilemma for the delivery of health care services in the Navy:

1. There is a desire to have health care services close and easily accessible to the active duty population.

2. Many aspects of modern medical practice have become so complicated, specialized, and expensive that they are more effectively practiced in large institutions.

3. Resources available for health care services are limited. To combat this set of problems, an organization structure has evolved which helps to alleviate the dilemma.

B. Organization of a Continuum of Care

In the Navy health care delivery system, a continuum of care exists which seeks to decentralize the less specialized and less expensive primary care, and centralize the more costly and more specialized secondary and tertiary care. In this continuum of care, the patient receives care at the institution nearest to him which is capable of handling his medical problem, but

regardless of where he initiates contact with the system, he has access, commensurate with his medical needs, to the entire spectrum of primary, secondary, and tertiary services provided within the system.

This structure aims to maintain the primary care services close to the people it is serving. These are the services the largest percentage of the population will require. Whether it is a pre-flight physical in a Naval Air Station dispensary, or emergency care in a ship's sick bay to stabilize a patient until he can be transferred, the services should be close, easily accessible, and tailored to the need of the population being served.

At the same time, the structure centralizes the more expensive secondary and tertiary services. The special skills, equipment, and facilities required to deliver this care can be utilized more efficiently as economies of scale are realized. The centralized facilities stand as a resource to provide the specialized care which cannot be provided in the dispersed primary care units. Thus, the centralized facilities function as an integrated part of the overall continuum.

The presence of primary, secondary, and tertiary services does not in itself guarantee the necessary continuum of care. A smooth continuum of care is present only when the patient referral patterns are well

established such that the individual patient can be moved smoothly and quickly from any entry point in the system through all appropriate levels and capabilities. The ultimate objective is to preserve, promote, and protect to the maximum the health and the fighting strength of the active duty population.

IV. Conclusions

A. The patient care functions inherent in the Navy Health Care System exist in a complex, interrelated array of varying care capabilities. This array can conceptually be viewed as a continuum of health care services.

B. The medical facilities (afloat and ashore) of the Navy and Marine Corps each contribute to the continuum of care and represent variable levels of capability within the health care system.

C. The Navy organization and resource allocation structure is superimposed upon this continuum of care. It would be erroneous to view the various echelons of Navy health care facilities as separate and distinct organizations. The important distinction to be made is that the various echelons of facilities, while separately administered must function as essential co-contributors to the overall Navy Health Care System.

SECTION B

NHCRC REVIEW OF DEFINITIONS OF THE ESSENTIAL ELEMENTS OF HEALTH CARE SUPPORT FOR THE OPERATING FORCES

I. Background

The NHCRC identified and provided broad definitions for the four major categories of health care required to support the operating forces.

II. Discussion

A comprehensive understanding of the Navy health care continuum requires identification of its major components. A review of existing and proposed doctrinal publications dealing with health care services and interviews of various medical authorities identified four major categories of Navy health care. The categories identified were Illness, Injury, and Wound Care, Preventive Medicine, Planning, and Logistics.

Injury, illness, and wound Care is the diagnosis and treatment of sick, injured, and wounded personnel. This care may be provided at facilities capable of any of four levels of care: routine care, which provides limited treatment and possible hospitalization; emergency care, which deals with lifesaving and unforeseen situations; definitive care, normally involving more sophisticated hospitalization; and, comprehensive care, which potentially requires extensive, highly specialized and long term hospitalization.

Activities which must be performed at any of these levels of care generally include receipt, evaluation, treatment, stabilization, and disposition of each patient.

The basic objective of injury, illness, and wound care is early return of the patient to a duty status, or such other disposition which is indicated by the circumstances.

Preventive medicine is the examination or alteration of those conditions which may result in deterioration of health, functional ability, or longevity.

Components of preventive medicine are epidemiology, occupational medicine, environmental health and sanitation, industrial hygiene, vector control, and health education.

The preventive medicine process includes the requirement to establish plans consistent with the objectives of overall health care planning in support of the operating forces; inspection, monitoring and control of adverse health conditions; and, training of personnel in correct health safeguarding practices.

Health care planning is to assure, through logical and continuous analysis, the availability of sufficient resources to meet and maintain the health care requirements of the Naval service.

This process includes the identification of objectives, determination of requirements, examination of capabilities, and analysis of alternatives.

In order to undertake the process of Navy health care planning, operational and health care objectives must be identified. Health care objectives must be developed within the guidance and constraints resulting from operational objectives established to accomplish the overall mission.

The health care objectives which must be identified will include provision to prevent and care for injury, illness, and wounds, and identification of the logistics involved in accomplishing optimum health care and protection.

The planner must determine the personnel, equipment, facilities, and knowledge required to achieve these health care objectives. The quality and quantity of required support must be consistent with the priorities and demand determined by operational objectives.

Inherent in the health care planning process is an analysis of requirements versus capabilities to identify shortfalls, and determine alternative means by which to achieve the health care objectives. Review of these alternatives will enable a decision to be made as to which alternative will best achieve the defined medical objectives.

Health care logistics is the implementation and maintenance of a system which will ensure the availability of supply, transportation, maintenance, and facility resources in sufficient quantity and quality to meet and sustain health care objectives.

A major function of health care logistics is the timely and accurate identification and provision of supply required to enhance the successful delivery of health care services in a manner that precludes unnecessary procurement or excessive stockpiling.

Additional functions of health care logistics include the selection, coordination, and control of the various modes of transportation necessary to move required materials, personnel, and equipment; the assignment of resources, as required, to accomplish construction of facilities necessary to support health care objectives; and, the effective maintenance of personnel, equipment, and facilities committed to accomplish the health care effort.

The defined categories are each integral parts of the total health care continuum, and contribute to the total objectives of health care delivery.

III. Conclusions

A. The NHCRC found that a conflict exists in the definitions of the elements of health care contained within existing doctrinal publications. Utilization of the four

categories of health care identified by the NHCRC will be a major step in avoiding much of the conflict presently existing.

B. The NHCRC found the four health care categorations to provide a useful frame of reference for conduct of the Navy Health Care Review.

IV. Recommendation

CHBUMED use the definitions of health care categories identified by the NHCRC in order to provide a commonly understood frame of reference by which to facilitate discussion and communication between the medical department and the forces to which it provides health care support.

SECTION C

NHCRC REVIEW OF NAVY MEDICAL DEPARTMENT PERSONNEL AUGMENTATION TO THE OPERATIONAL FORCES

I. Introduction

The doctrinal method for providing augmentation of Medical Department personnel from Bureau of Medicine and Surgery commanded activities to units of the operational forces, including Fleet Marine Forces, was reviewed by the Committee.

II. Discussion

Formally described Medical Department personnel augmentation is available in two primary forms: team assignment as in Navy Surgical Teams; and, by individual assignment to immediately fill Table of Organization (T/O) Fleet Marine Forces billets.

A. Team Augmentation - Certain hospitals have been assigned responsibility for sponsorship of special health care teams, e.g. surgical teams. Such teams are to be requested by the Fleet CINC from CNO who will direct appropriate action of CHBUMED. Response can normally be accomplished within 48 or 72 hours. The requesting activity must provide facilities and administrative support for these teams. BUMEDINST 6440.1E applies.

B. Individual Augmentation to FMF - Selected Navy and Marine Corps activities are assigned the responsibility

to provide augmentation Navy personnel to support the Fleet Marine Force. Augmentation personnel are pre-designated by name to satisfy the skill requirement placed against the specified commands by CHBUMED. TAD deployment of such personnel is upon request by major Fleet Marine Force units. FMFPAC and FMFLANT will transmit collated requirements to CHNAVPERS and CHBUMED, who will select the commands to respond. SECNAVINST 6440.1A applies, and is contained in Appendix G.

III. Conclusion

The means for rapid personnel augmentation exist both regarding team support to the fleets and FMF, and individual augmentation; however, SECNAVINST 6440.1A, directs that FMF request immediate personnel support in a manner not consistent with the established chain-of-command, in that it excludes the fleet CINC and CNO/CMC.

IV. Recommendation

CHBUMED, assisted by appropriate offices within HQMC, initiate action to revise SECNAVINST 6440.1A which will cause adherence to established chain-of-command procedures when FMF major commands request medical personnel to fill II and III MAF T/O billets.

SECTION D

NHCRC REVIEW OF MEDICAL DEPARTMENT EDUCATION AND TRAINING

I. Introduction

In accordance with the NHCRC Charter which tasked a problem oriented approach to the review of the Navy Health Care System (NHCS) and development of objectives from a CNO management perspective, the Committee reviewed the centrally managed Medical Department education and training program. The purpose of this review was to extract both instructive and informational data and to focus on substantive problem areas and ongoing initiatives.

II. Background

A comprehensive review of Navy Medical Department education and training was conducted. The outline used to conduct this review is reproduced in Appendix H. Material obtained for evaluation was voluminous (some 300 pages) thus precluding reproduction and distribution of the entire contents. The interested reader may locate particular reference subjects in the review index on education and training in Appendix H.

III. Method

The basic approach was to obtain both oral and written material using the review outline as a guide. This outline covered the following general subjects:

1. Organization, authority, and guidance
2. Purpose of Navy Medical Department E&T

3. Descriptions of programs
4. Discussion of accountability
5. Determination of requirements
6. Resources, programming, and budget
7. Education and training efforts in support of the operating forces.

IV. Discussion

A. General

Training and education in the Medical Department has a foundation similar to that of the remainder of the Navy in that for many of the manpower skills needed, the system must "grow its own." This is expected because of the Navy objective for its personnel to possess consistent, competent and proficient performance skills. In recognition of these essential factors, education and training within the Medical Department must encompass both military and medical areas. Thus the breadth of training spans initial skill, advanced skill, educational subsidy, military training, and professional health care training. Charged with the responsibilities for providing a broad range of health care support services under conditions of growing beneficiary demand and entitlements, the Medical Department must maintain extensive capabilities to train personnel to provide illness, injury, and wound care, preventive and environmental medical and dental services, health care planning, and logistics.

In contrast to training of the hardware oriented Naval line, medical department training is generally conducted in a different setting. In addition to use of modular and simulator based instruction, medical department skills remain heavily dependent upon experiences gained from individual relationships and highly personal direct patient interfaces. Another difference from general Navy instructional practices deals with legalities and standards of patient care as discussed elsewhere in this NHCRC review (Civilian Relationships and Influences, SECTION III, Section A). There are, therefore, dual Navy medical department skill training requirements; one set is based upon Naval standards of preparedness, responsiveness, and readiness, and the other set is based upon the legally recognized standards of civilian health care educational practice.

b. Organization

Subsequent to an extensive CHBUMED directed study (Naval Medical Department Education and Training Command Planning Board), Medical Department education and training managerial and activity reorganization was approved (OPNAVNOTE 5450, 7 June 1974). The organizational framework and relationships currently exist within the office of the Chief of the Bureau of Medicine and Surgery and within the Naval Health Sciences Education and Training Command.

The mission and function statements for both the BUMED Special Assistant for Medical Department Education and Training (BUMED Code 0011) and for the Naval Health Sciences Education and Training Command are contained in Appendix H. Important to an understanding of the link with managerial responsibility to OPNAV is the formalized ADDU relationship of BUMED Code 0011 to the Director of Naval Education and Training (DNET). This is further described in this section on resource management and programming of education and training.

C. Purpose

The goal of the Medical Department Education Program is stated by CHBUMED as: "...Simply to provide skilled health service professionals and paraprofessionals in sufficient numbers distributed among the five corps and numerous specialties to carry out the mission and functions of the medical department and to provide for the accountable maintenance of a high standard of individual professional competence."

D. Programs

Abbreviated descriptions and purposes of centrally managed medical department education and training programs can be found in Appendix H, entitled "U.S. Navy Medical Department Education and Training: 1975 An Overview."

E. Accountability

The Navy Medical Department concept of accountability is predicated upon the assumption that it is the intent of the government to provide the same scope and quality of health care services for military personnel and their dependents as is available to other citizens. Interpretation of the Federal Tort Claims Act requires that standards of performance within the Medical Department be equal to or better than the civilian sector. Therefore, competence can only be measured and maintained by properly applying to the federal medical services the recognized standards of practice and qualifications of health care personnel as established by professional organizations, academic institutions, and federal and state legislation.

It is the policy of the Navy Medical Department to set minimum standards for education and training of both professional and technical personnel which conform to the standards applicable to similar categories of health care personnel in the civilian sector. These standards include both the qualification of personnel and the accreditation, where appropriate, of formal education and training programs which conform to criteria established for similar civilian health care personnel and programs.

F. Education and Training Requirements

Determination, administration, and management of training requirements are policy matters within BUMED. These requirements are submitted to CNO (OP-099 (DNET)) who authorizes student loads for each budget execution year. Based on authorized loads, quotas are established and selections are made. Orders of personnel into training are prepared by coordinated BUMED and BUPERS actions. The NHSETC centrally manages education and training programs to meet established requirements. Billets and qualifications are developed by BUMED to meet its health care responsibilities. Training requirements are planned to offset projected skill shortages and are based on accessions, losses, and updated billet requirements.

G. Resources

Appendix H summarizes the FY-1977 NAVCOMPT budget submit. It shows student loads, civilian E/S and M/Y, and O&M,N costs by school and location for specialized training. It also includes a summary of costs and average on board figures for professional training. Not fully reflected in this summary are decrements recently imposed by PDB action, the POM 77 TRP, and congressional action. These actions are seen in FY 78 and beyond:

- | | |
|-----------------------------------|----------------|
| 1. Nurse Corps Candidate Program | } Phase out by |
| Navy Enlisted Nurse Corps Program | |
| 2. Physician's Assistant Program | } Discontinue |
| | |

- | | |
|--|---------------------------------|
| 3. Senior Medical Student Program | } From 55 to 0
by FY 80 |
| 4. Ensign 1935 Program (Medical Service Corps) | } From 60 to 34
by FY 78 |
| 5. Dental Officer Scholarship Program | } From 38 to 22
by FY 78 |
| 6. Medical Officer Scholarship Program | } From 201 to 0
by FY 80 |
| 7. Armed Forces Health Professions Scholarship Program | } From 1575 to 1451
by FY 78 |

With these reductions the recently determined POM 78 working dollar base for E&T has been determined to be just over \$63 million - the lowest figure in the last three POM years.

Planning guidance for development of the Navy POM for FY 1978-82 is managed for E&T through conjoint action and authority of DNET (mission sponsor) plans for development of the E&T portion of POM-78 and BUMED (Code 020 and 0011) participation in the planning process. The details of POM-78 DNET guidance are provided in CNO memo Ser 9920/72441 of 12 September 1975. BUMED planning and programming guidance was issued 7 October 1975 as BUMPPG 78-1.

H. Programs in Support of the Operational Forces

(Not otherwise addressed above)

These BUMED programs include both specialized and professional training. They are listed by name as follows:

Aerospace Medicine Residency

Flight Surgeon Course

Aviation Medical Officer Course

Aerospace Physiologist Course

Aerospace Experimental Psychologist Course

Aerospace Medicine Technician (HM-8406)

Aerospace Physiology Technician (HM-8409)

Preventive Medicine Technician (HM-8432)

Special Operations Technician (HM-8492)

Undersea Medicine Course

Deep Sea Diving Course

Saturation Diving Orientation

Radiation Health Officer Course

Nuclear Submarine Medicine Technician (HM-8402)

Medical Deep Sea Diving Technician (HM-8493)

Preventive Medicine Residency

Outservice Residency -

e.g. Radiobiology

Tropical Medicine

Hyperbaric Physiology

Selected short courses

e.g. Current Aerospace Medicine

Orientation to Aviation PE

Refresher course ID corpsmen

Refresher course in Hearing Conversation

Food Service training

Dental Casualty training

Microbiology lab techniques

Recognition and Treatment of Diving

Casualties

Preventive Medicine refresher courses

Preventive Medicine seminars

Indoctrination/Orientation courses

The Marine Corps has two Field Medical Service Schools designed to train members of the Navy Medical Department in combat survival and field medical and dental practices; and in the several associated professional, technical, military tactical and defensive techniques with which field medicine is closely related. The scope of the officer (3 weeks) and enlisted (5 weeks) courses is on general military subjects, individual and small unit tactics, weapons orientation, military drills, physical conditioning, field medical/dental support, emergency medical care, casualty evacuation, organic and medical supply in the field, preventive medicine and health care aspects of specialized warfare operations.

In addition, there is a quota of one MSC officer/year to attend the Marine Corps Amphibious Warfare School course at Quantico and one MSC officer/year to attend the Marine Corps Command and Staff course at Quantico. A single quota is also available for the Marine Corps Ground Officer Supply School at Camp Lejeune.

Issuance of the revised SECNAVINST 6440.1A is expected to place a more stringent requirement for training Medical Department personnel who are identified as augmentees for the FMF. Current resource limitations may

impede the extent of training obtained. However, the instruction directs priority attendance of designated personnel in courses of field and operational medical support.

V. Findings

A. General

Based upon information provided in the review of Medical Department E&T and obtained from an NHCRC/Fleet health care workshop, several problems were identified. Substantive initiatives were also recorded. The review indicates that the principal thrust of the Medical Department E&T program emphasizes skills associated with the diagnostic and therapeutic aspects of direct health care, i.e., acute and chronic illness and injury. Furthermore, this emphasis has occurred at the expense of training personnel in Naval health care skills. This problem exists in each of the Corps communities with the greatest weaknesses in MC, followed by NC, MSC, HC, and lastly the DC, in that order. Recognition of this problem exists but reorientation of Navy Medical Department personnel is more than a simple matter of doctrinal change. Furthermore, the ever present demand for direct patient care services continues. (The extent of patient care services and beneficiary entitlements has been dealt with elsewhere in this review.)

B. Medical Corps

1. Problems/Findings. Many of the problems related to E&T of the medical corps along with all other corps communities have been addressed in the section on "Personnel," SECTION VI, Section B.

In response to the loss of the Berry Plan input and emphasis upon the need for medical officers with civilian equivalent specialized clinical skills to meet beneficiary patient care demand, medical officers were assigned to residency training in excess of approved billets.

A number of other prominent problems perceived to be symptomatic of emphasis upon the civilian equivalents of highly specialized definitive patient care health care support skills follows:

a. Medical Officers receive insufficient preparation to perform adequately and appropriately in operational assignments.

b. There is insufficient training of medical officers for the responsibilities of conducting non-medical personnel training (e.g., first aid, principles of healthier living, industrial health protection, sanitation, etc.).

c. There is insufficient motivational training for development of unique Naval officer (medical-noncombatant) cognitive and attitudinal skills.

d. There is insufficient retention of basic Naval medical officer skills once medical officers become clinically specialized.

e. Medical officers appear to be well trained for patient care clinical needs (i.e., diagnosis and therapy functions) but at the expense of other Navy mission essential skills.

f. There is insufficient training of medical officers to perform all their assigned responsibilities as augment and specialty team personnel.

g. Medical officers are insufficiently sensitive to the foremost priority of providing health care support services to AcDu personnel in general and operational force personnel in particular.

h. Other problems of a different scope must be mentioned and include:

(1) Dollar support of acquisition programs has eroded from imposed decrements so as to threaten sufficient accession of medical officers by FY 1981.

(2) Quotas available for attendance of medical officers at senior service schools are virtually nil.

(3) PBD actions have eliminated the Physician's Assistant training program.

(4) Maintenance of sufficient levels of O&M,N\$ to support continuing medical education at minimum

essential requirements is unsatisfactory. (See Problems, All Corps Communities - C.I.d.)

2. Initiatives. CHBUMED analyzed the Billet/Body misalignment and overemphasis upon civilian equivalent (CHE) specialization and has taken the following initiatives which should assist in resolution of this problem:

a. Elimination of 12 separate GME programs at NRMC Philadelphia.

b. Elimination of 3 separate GME programs at NRMC Great Lakes.

c. Establishment of a "no billet - no body" assignment policy.

d. Establishment of an inviolate ceiling of 25% of the total medical officer E/S to be in all GME billets to include training billets in Naval operational medicine specialties. This will effect a real 19% reduction in the current overmanning of GME billets to result in authorized billet/body parity.

e. Requested reestablishment of a quota of ten in Senior Service Schools for medical officers.

f. Established a policy of limiting entry of Naval 1st year GME trainees to no more than 50% of available positions at advanced year GME levels.

g. Established a "requirements projected" planning system for civilian deferrment of Armed Forces

Health Professions Scholarship Program (AFHPSP) students into an uninterrupted continuum of specialty training.

h. Developing a "requirements projected" planning system for in-service specialty training input.

i. Developing an entirely new Naval operational medical specialty GME program without incrementing authorized training billets.

j. Developed for selected AFHPSP students a pilot shipboard orientation program during a 45 day AcDu training period away from medical school.

k. Developing in conjunction with CNET an AFHPSP student Naval officer orientation program to be conducted at Newport.

l. Developing initial implicit educational objectives for all Navy GME programs.

m. Developing a two week preparatory "Command Performances Course" for prospective commanding officers.

n. Participated with ASD (H&E) in developing longer AcDu obligation periods for GME.

o. Participating with the Air Force and Army in assuring that no medical officers will attend civilian full-time sponsored out service training in GME if the desired authorized training capability is available in either sister service GME programs.

C. All Corps Communities

1. Problems. In general the Navy Medical E&T effort has succeeded in producing competent and proficient personnel to provide civilian health care support equivalent (CHE) clinical skills in support of patient care demand and entitlement. However, the primary weakness of E&T is insufficient training for acquisition of general Naval (USN) skills and Naval health care support equivalent (NHE) skills.

A listing of illustrative problems follows:

a. There are examples of individual Independent Duty Corpsmen unprepared to fulfill assigned shipboard responsibilities; e.g., medical department representative responsibilities, training of non-medical personnel, experience with trauma, health safety and environmental health training, health promotion skills, NBC training, communication skills internal and external to commands, non-combat disaster training.

b. There is no formal system for iteration of projected training input plans by quality and quantity in all corps communities (excepting the HC/DT community).

c. Resource decrements have eroded sponsored subsidized acquisition programs; e.g., elimination of nurse corps programs, reduction of dental and medical service corps programs.

d. There is insufficient O&M,N\$ support for civilian equivalent (CHE) and Navy equivalent (NHE) clinical continuing education; e.g., limited support for dental corps and medical service corps, and minimal support for nurse corps and the HC/DT community. A BUMED estimate of additional O&M,N\$ needed for continuing education for all officer/enlisted communities revealed the following: CHE \$2,400,000 and NHE \$250,000.

e. There are insufficient resources to provide short course training to comply with the Occupational Safety and Health Act (OSHA). A BUMED analysis of the full impact of projected funding requirements for this support has not been developed at this time.

f. There is insufficient preparation for augmentation and contingency operations.

g. There is insufficient understanding of responsibility in the area of uniquely Naval Medical Department personnel skill performance.

h. There is insufficient appreciation of certain key requirements: e.g., preparedness, readiness, and responsiveness.

i. There is likelihood of continuing end strength reductions of uncertain magnitude.

j. There is no computerized retrieval system for management of training and student data. The Navy

Integrated Training Resources Administration System (NITRAS), managed by CNET, may help this need in the future.

k. There are continuing pressures to highly specialize in certain skill areas at the expense of maintaining balanced, adequate skills in all categories of health care support.

2. Initiatives. CHBUMED has pursued numerous initiatives to resolve many of these problems. Some examples are:

a. Established the 3rd echelon Naval Health Services Education and Training Command to consolidate management of all medical department E&T efforts.

b. Conducted workshops to review, revise, and shorten training efforts; e.g., complete revision of the ID corpsmen curriculum shortening of pharmacy training, and consolidation of "C" school training.

c. Participated in Interservice Training Review (ITRO) activities resulting in sharing of facilities and resources with progressive elimination of unnecessary duplication of training efforts.

d. Pursued development of a formalized accounting of medical department officer training for inclusion in NITRAS.

e. Establishing workshops to enhance training efforts in: preventive and environmental medicine,

augmentation and contingency preparation, and skill enhancement in health care planning and logistics.

VI. Conclusion

The overriding concern of the Navy Medical Department is fulfillment of its mission in providing all categories of health care support for the Naval establishment at adequate levels and within the limits of available resources. In achieving this task the foremost priority for all education and training programs is to meet the minimum essential requirements to support AcDu Naval personnel. The remainder of formal training efforts must then be conducted in descending order of priority, remaining within the limits of authorized requirements, student loads and billets, and available resources. All formally conducted, organized, and managed Medical Department E&T must be based upon formalized training plans published at least annually to include an analysis of training requirements by corps community and individual NOBC/NEC within a FYDP context.

VII. Summary

This review of education and training has focused on the need for Navy Medical Department E&T efforts to pursue correction of major concerns listed. These concerns provide the basis for development of a proposed CNO Objective Statement on Navy Health Care E&T. There is a need for E&T to develop and maintain a balanced emphasis upon all four categories of Navy HC support to ensure adequate and

appropriate training of Navy health care personnel in the three interdependent areas of:

- A. General Naval (USN) skills.
- B. Naval health care support equivalent (NHE) skills.
- C. Civilian health care support equivalent (CHE) skills.

Figure D-1 is the NHCRC Objective Statement on E&T in the NHCS.

HEALTH CARE OBJECTIVE STATEMENT
2. MEDICAL DEPARTMENT EDUCATION AND TRAINING (E&T)

AREAS OF CONCERN:

I-161
"SURGEON GENERAL/CHIEF, BUREAU OF MEDICINE
AND SURGERY ESTABLISH AND CONDUCT A REQUIRE-
MENTS BASED EDUCATION AND TRAINING PROGRAM
THAT DEVELOPS AND MAINTAINS THE APPROPRIATE
BALANCE OF NAVAL HEALTH CARE SUPPORT PERSONNEL
THAT ARE PROFESSIONALLY PROFICIENT AND CLINICALLY
COMPETENT IN THE NAVAL OFFICER AND ENLISTED,
NAVAL HEALTH EQUIVALENT, AND CIVILIAN HEALTH
EQUIVALENT SKILLS REQUIRED TO SUPPORT THE NEEDS
OF THE NAVY HEALTH CARE SYSTEM BENEFICIARIES."


- 
1. REQUIREMENTS BASED E&T PLANS
 2. NAVAL SKILLS, GNT (INITIAL AND CONTINUING)
 3. NAVY HEALTH EQUIVALENT SKILLS, BASIC
 4. CIVILIAN HEALTH EQUIVALENT SKILLS GENERAL AND SPECIALTY

FIGURE D-1

APPENDIX H

1. NHCRC Memo #10 of 12 August 1975, Subj: Descriptive Comprehensive Review of Medical Department Education and Training; Request for.
2. Index of Comprehensive Descriptive Review of Education and Training; By General Subject Category, Tab, and Content.
3. Special Assistant for Medical Department Education and Training.
4. BUMEDINST 5450.47G, 0011.
5. U.S. Navy Medical Department Education and Training: 1975, An Overview.
6. E&T NAVCOMPT Budget Submit FY 1977.

SECTION E

NHCRC REVIEW OF MEDICAL RESEARCH AND DEVELOPMENT

I. Introduction

This section of the review provides background information with an overview of management of the medical research and development system and illustrates this Research and Development (R&D) subcomponent as a part of the Navy and the Navy Health Care System (NHCS).

II. Method

Information was obtained from material solicited directly from the Navy Medical Research and Development Command (NMRDC) and from OPNAV 098E. Additional material was gained from personal interviews and discussions with selected personnel from the NMRDC and the OPNAV organization. Owing to the known tight managerial guidelines within which the NMRDC is constrained to operate, a comprehensive assessment was not performed.

III. Discussion

A health care system can be defined in its most general terms as a functional system which brings together the best possible knowledge, skills, competencies, and institutional resources to assure as early, continuous, and complete patient and health care as is available and possible. Traditionally the three inseparable and essential parts of such a system are held to be direct and indirect health and

illness care, education in the health care fields, and lastly research. The Navy plans for and provides such a generally defined health care system of which a recognized segment consists of an organized and managed research and development effort.

A. Organization

The organization of medical R&D is set out in the NAVMED Organization Manual (BUMEDINST 5430.4A) as follows:

R&D affairs within the Bureau of Medicine and Surgery are the responsibility of the Special Assistant for Medical Research and Development (BUMED Code 0012) exercised through the Commanding Officer, Naval Medical Research and Development Command (NMRDC), National Naval Medical Center, Bethesda, Maryland. The Special Assistant for Medical Research and Development has as his mission to serve as the executive for Navy Medical Department RDT&E matters and as advisor to the Chief, Bureau of Medicine and Surgery on all policies and requirements concerning Navy Medical Department R&D programs. The Director's functions are to maintain liaison with OSD (DDR&E), ASN (R&D), OPNAV, ONR, NAVMAT, Departments of the Army and Air Force, and other governmental agencies and civilian activities on matters pertaining to Medical Department Research, Development, Test and Evaluation programs. Further, he coordinates the actions of Bureau organizational components through the various Assistant Chiefs of the Bureau to ensure effectiveness of Medical Department Research, Development, Test and Evaluation Programs....

The Commanding Officer, NMRDC, who is also the Director of Medical Department RDT&E, has as his mission to manage RDT&E programs concerned with the health, safety, and performance of Naval personnel. He commands the Naval Medical Department Research and Development Laboratories or activities and supports their RDT&E missions by providing personnel, funds, and facilities. He directs, plans, programs, budgets and documents RDT&E efforts in health services and technology, manpower effectiveness and operational medicine, and dental support

systems in response to Navy and Marine Corps RDT&E requirements. He determines requirements and qualifications, and recommends procurement, training, assignment and distribution of research and development personnel. Furthermore he performs RDT&E staff functions for the Surgeon General. He provides medical and dental professional and technical guidance and assistance to the Navy and Marine Corps in the planning and conduct of RDT&E aspects of weapons systems, life support systems and personnel protection. Finally, he coordinates Navy Medical Department research with other government agencies, civilian organizations and foreign governments.

The broad organizational objectives and responsibilities of the medical research effort as detailed above include a complex network of intra and inter relationships both within and without the direct confines of the Navy research community. The substance and extent of these relationships need not be further delineated here since they are well documented in a formal publication, "Department of the Navy RDT&E Management Guide-NAVSO P-2457 (Rev. 1-75)". This recently revised publication serves as the basic reference document for Navy RDT&E management procedures. Though not a directive itself, the purpose of this guide is to help participants in Navy RDT&E understand the overall "system" and to identify specific directives which provide detailed current guidance. As such this manual is composed of information drawn and summarized from over 200 DOD and Navy Directives and Instructions dealing with various aspects of R&D management. This guide is organized into seven major chapters, and a separate section is devoted to nine appendices, a master reference list, and an index. The seven main

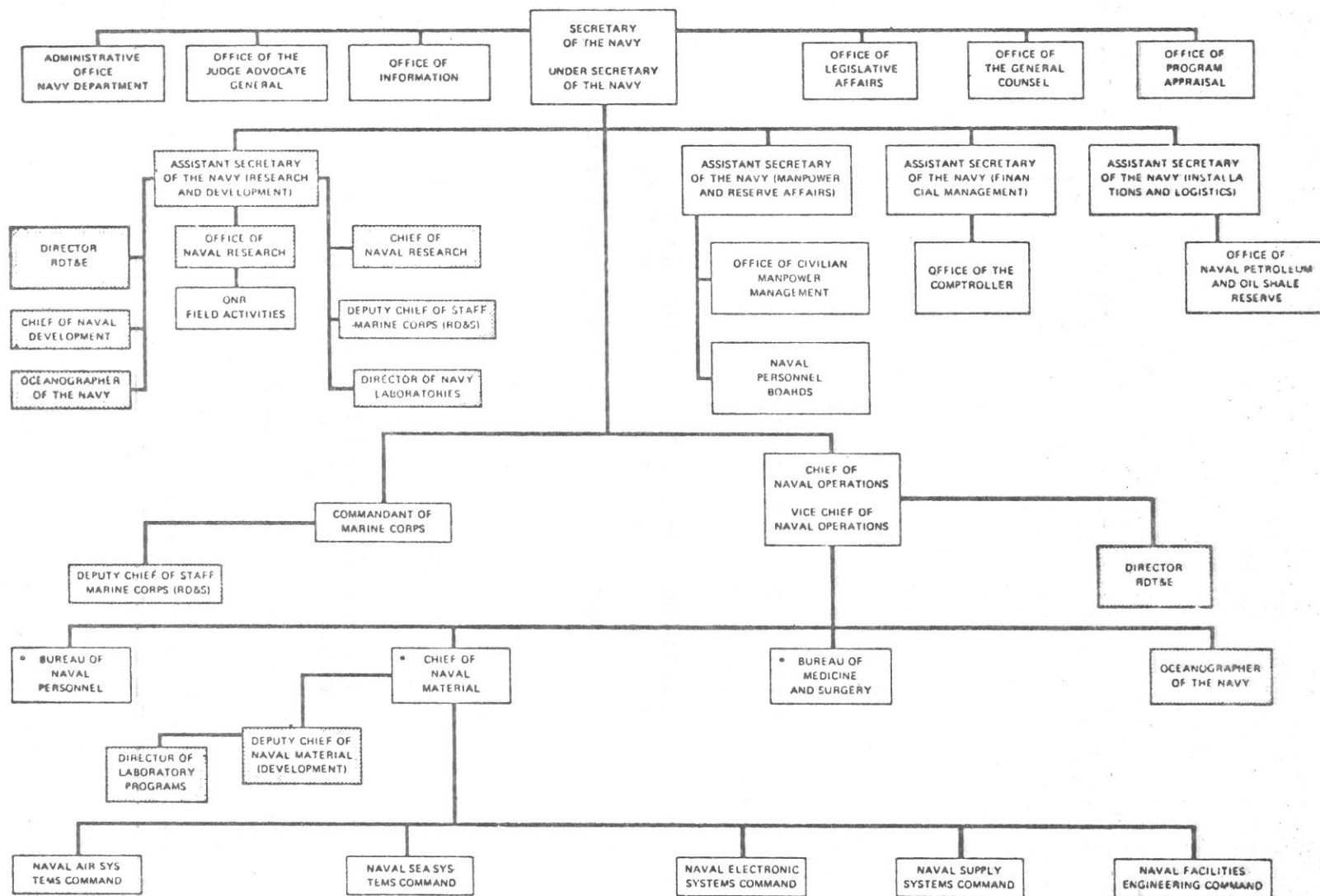
chapters deal with:

1. Organization for RDT&E
 2. Planning
 3. The Five-Year Defense Program Process
 4. Preparation and Justification of the Budget
 5. Execution of the RDT&E Budget
 6. Execution of Research and Development Effort
 7. Test and Evaluation
- B. Organizational Structure

In brief, the Navy Medical RDT&E program organizational structure has been summarized in the accompanying schematic figures:

- | | |
|------------|--|
| Figure E-1 | Principal Department of the Navy
Headquarters Organization for RDT&E |
| Figure E-2 | Navy Medical R&D Organizational Structure
Command Relationships |
| Figure E-3 | Navy Medical R&D Organizational Structure
Planning and Programming |
| Figure E-4 | Navy Medical R&D Organizational Structure
Budgeting and Funding |
| Figure E-5 | Navy Medical R&D Organizational Structure
Requirements Information Flow |
| Figure E-6 | Navy Medical Research and Development
Command |

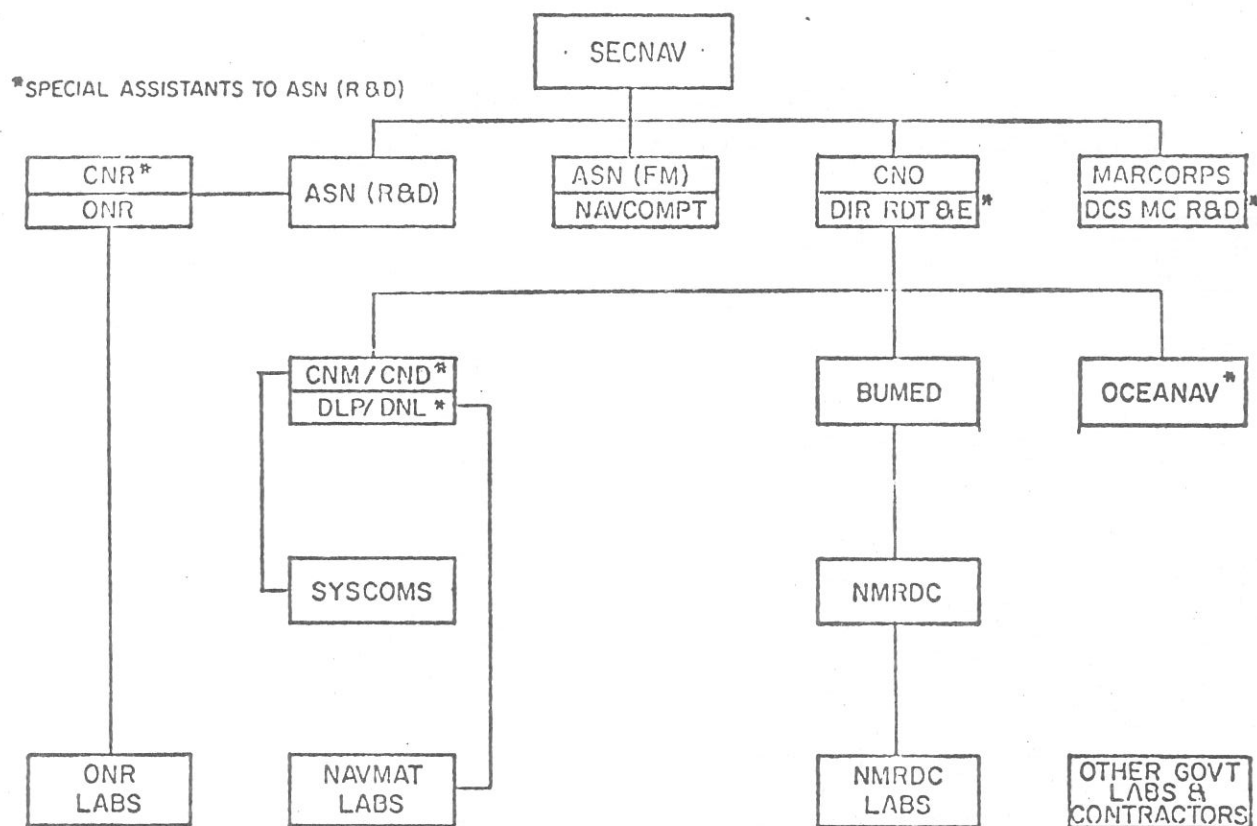
For the most part these schematic figures are self-explanatory. They depict the linear flow of authority and communication. In Figure E-3, there are explicit numbers placed along specified lines; i.e. 6.1, 6.2, 6.3, 6.4, and 6.5. These numbers relate to major program categories



*NOTE: Also responsible directly to CMC for Marine Corps needs

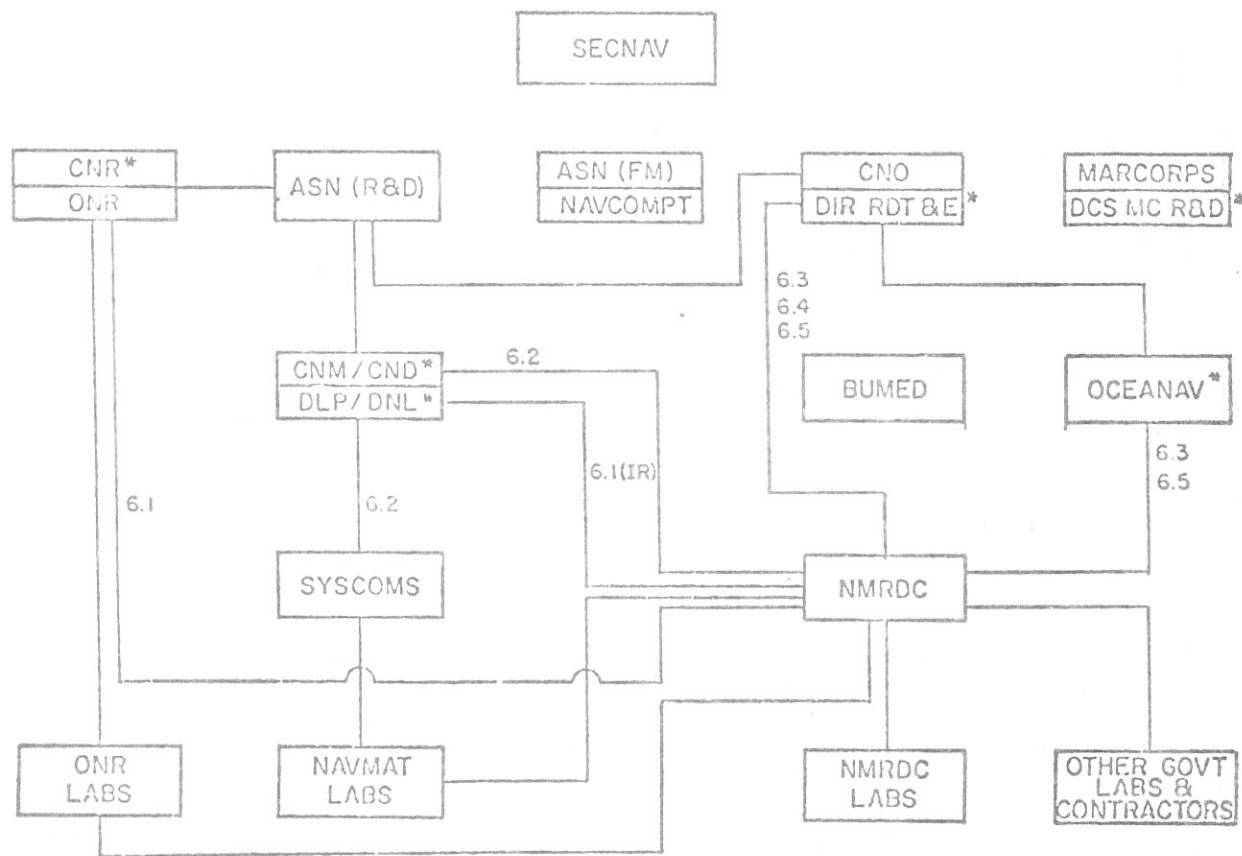
Principal Department of the Navy Headquarters Organization for RDT&E.
(Principals for RDT&E highlighted)

Figure E-1



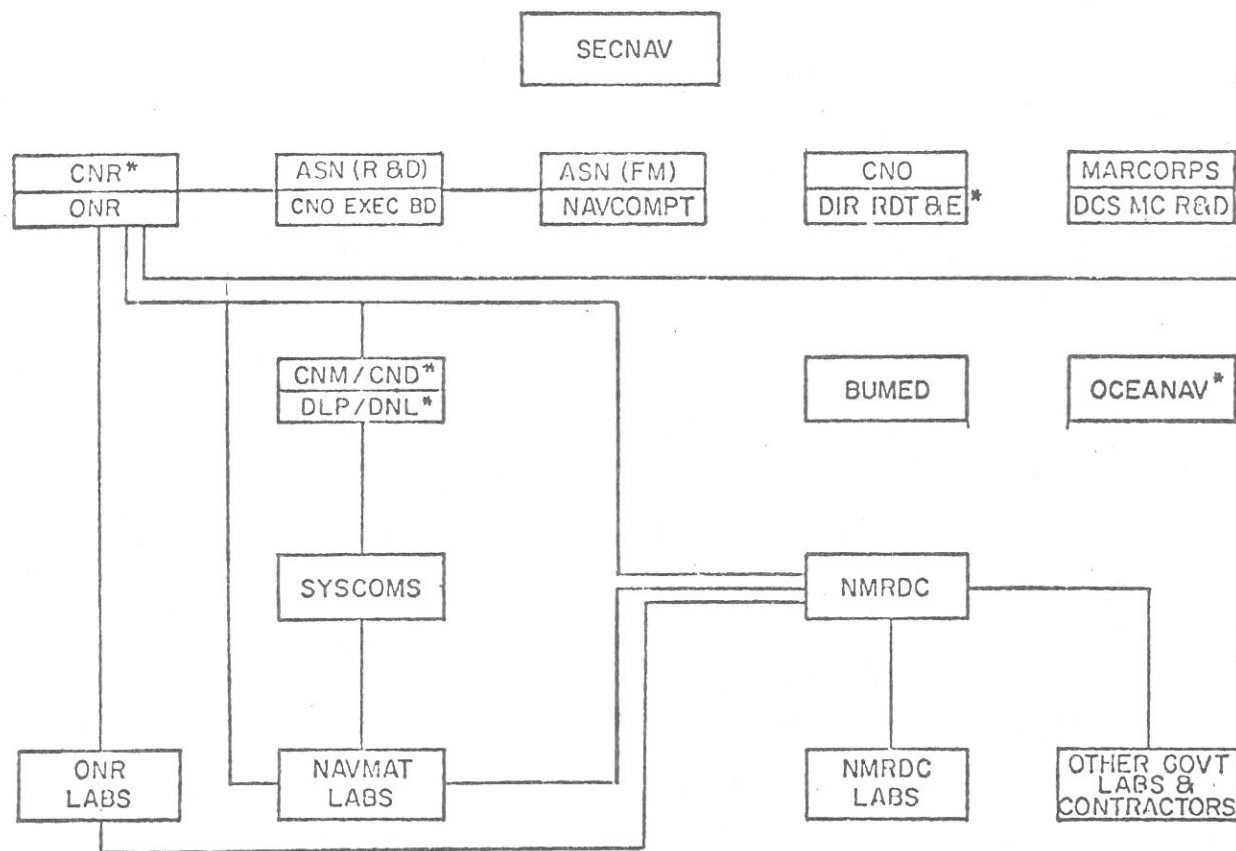
NAVY MEDICAL R & D ORGANIZATIONAL STRUCTURE
COMMAND RELATIONSHIPS

Figure E-2



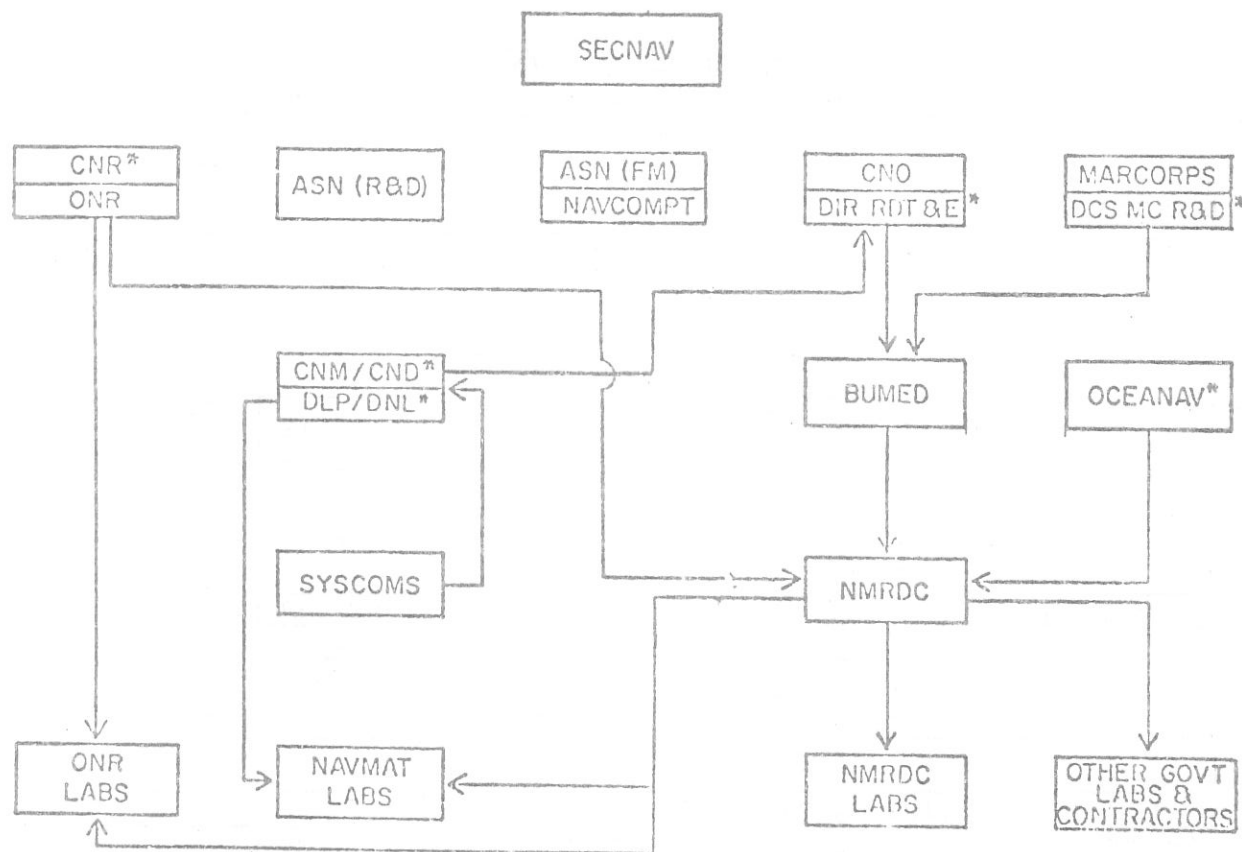
NAVY MEDICAL R & D ORGANIZATIONAL STRUCTURE
PLANNING AND PROGRAMMING

Figure E-3



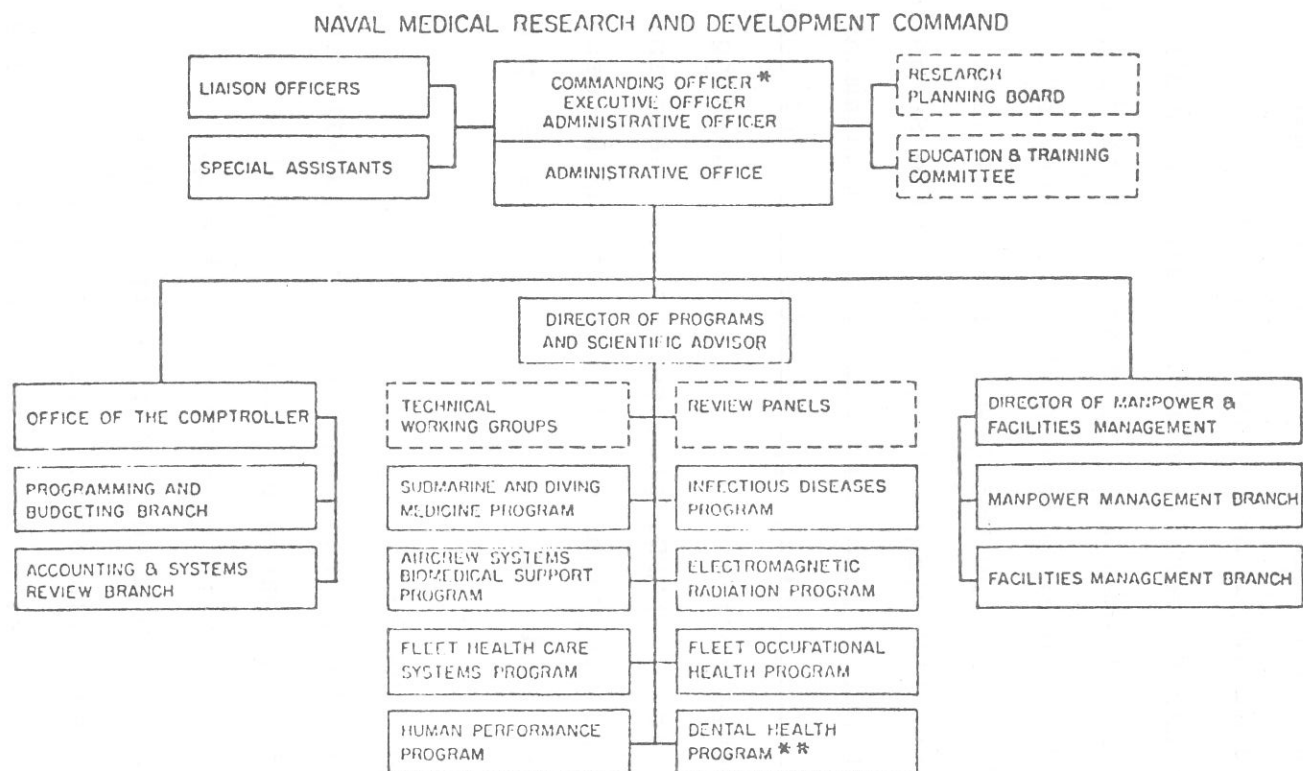
NAVY MEDICAL R&D ORGANIZATIONAL STRUCTURE
BUDGETING AND FUNDING

Figure E-4



NAVY MEDICAL R & D ORGANIZATIONAL STRUCTURE
REQUIREMENTS INFORMATION FLOW

Figure E-5



* SPECIAL ASSISTANT FOR MEDICAL RESEARCH AND DEVELOPMENT
TO THE SURGEON GENERAL

** PROGRAM MANAGER SERVES AS SPECIAL ASSISTANT FOR
DENTAL RESEARCH TO THE CHIEF, DENTAL DIVISION, BUMED

Figure E-6

which are named respectively: independent research, exploratory development, advanced development, engineering development, and lastly management and support. Upon review of these figures it becomes immediately apparent that Figures E-3 and E-4 indicate an isolation of the Bureau of Medicine and Surgery from the primary channels of communication and information. In practice this is not so, owing to the double hatted responsibilities vested in the Commanding Officer of the NMDRC who is in fact also the Special Assistant for R&D within the Office of the Surgeon General and Chief BUMED. Thus information and management flow patterns are maintained at appropriate levels of control. For example, to ensure continuity in the annual planning and programming cycles, CONMRDC provides program data input into the Planning and Programming Division of the Bureau of Medicine and Surgery (Code 02) in a controlled participatory fashion.

C. Program Description

Navy Medical RDT&E programs are concerned with the health, safety, and performance of Naval personnel and provide a capability which is responsive to the operational requirements of the Navy and the Marine Corps. These programs are conducted in close collaboration with the Biological and Medical Sciences Division of the Office of Naval Research. Medical RDT&E Programs fall into eight major descriptive title areas, each of which describes component areas of

concern. They are as follows:

1. The Submarine and Diving Medicine program is concerned with research and development on medical problems peculiar to submarine and diving environments and provides the biomedical knowledge necessary for the safe support of deep submergence operations and the attainment of specific underwater operational goals.

2. The Air Crew Systems Biomedical Support program incorporates R&D efforts on medical problems on aviation physiology, impact injury prevention, protection against high G forces, human factors in aircraft design, and prevention and treatment of illness in Naval aircrewmen.

3. The Fleet Health Care Systems program encompasses research and development in shipboard and field medical and dental facilities design, patient evacuation vehicles, remote medical diagnosis systems, determination of health patterns in Naval populations to estimate requirements for the health care system, and other efforts concerned with efficient delivery of health care to personnel engaged in fleet operations.

4. The Human Performance program comprises R&D projects on human behavior and performance effectiveness in operations systems and environments of Naval service, to include: research on the measurement and prediction of human performance under operational stresses of Naval systems from which to develop human factors criteria for selection,

training, engineering, and work procedures; research on the behavioral and psychological aspects of health and safety under operations and stressful duties of Naval service from which to develop criteria for medical screening and safety standards.

5. The Trauma Care program is directed toward the development of an improved trauma care system to reduce losses from combat injuries; e.g., develop improved capability for initial care and management of severely injured casualties; develop frozen blood component system (red cells, platelets, white cells) for shipboard and field use; develop improved capability for reconstructive surgery and transplantation to replace destroyed body components.

6. The Infectious Diseases program is concerned with research and development on the immunology, prevention, treatment, and control of infectious diseases including: development and testing of vaccines against viral, bacterial, parasitic and rickettsial diseases; etiologic and epidemiologic studies, disease vector control technology, chemotherapy and prophylaxis.

7. The Fleet Occupational Health program addresses occupational hazards from clinical, physical and biologic stresses in operational environments (including heat, noise, vibration, and atmospheric contaminants), determining human exposure limits, and developing effective measures for personnel protection.

8. The Dental Health program relates to research and development efforts on oral disease, hazards protection, delivery of dental care and repair of maxillofacial injury.

As a further description of the medical programs addressed above, Table E-1 provides a detailed profile of the R&D programs by funding for FY 1975 and 1976. As can be seen from the table the areas which received principal support were in Diving Medicine, Deep Submergence Biomedical Development, Electromagnetic Radiation, Aircraft Impact Injury Prevention, Health Care, Performance and Stress Tolerance, Trauma Care Systems, Infectious Diseases, Occupational Health, and Dental Health.

D. Project Review Mechanisms

Medical R&D project proposal and continuance reviews are based upon specific guidance provided by ONR, NAVMAT and OPNAV in accordance with research objectives. However, the regulatory authorities in NMRDC do not utilize formal written quantitative criteria as a priority setting mechanism for the assessment and approval of project proposals and individual project continuance. Owing to the necessity for a flexible stance to permit rapid response to Navy and Marine Corps iterated and changing requirements, there are nine nonweighted judgmental factors used in formal medical R&D periodic project review. These factors are listed as follows:

TABLE E-1
MEDICAL R&D FUNDING APPORTIONMENT BY PROGRAM
FY75 & FY76

<u>PE/PROJ/TASK/SHORT TITLE</u>			<u>FY75</u>	<u>FY76</u>	<u>% Change</u>
<u>Submarine & Diving</u>					
61153N	MR041.01	Physiology	203	195	
	MR041.06	Biochemistry	175	187	
62758N	MF51.524.005	Submarine Medicine	140	177	
	MF51.524.014	Diving Medicine	891	990	
63713N	M4306	Deep Subm Biomed Dev	3160	3423	
63856N	M4327	Spt for Sub Systems	-	202	
			<hr/>	<hr/>	
			4559	5174	
FY74 Funds Applied			160		
			<hr/>		
			4719		+ 10
<u>EMR</u>					
61153N	MR041.03	Biophysics	160	160	
62758N	MF51.524.015	Electromagnetic Rad	1211	1404	
			<hr/>	<hr/>	
			1371	1644	
FY74 Funds Applied			240		
			<hr/>		
			1611		+ 2
<u>Aviation</u>					
61153N	MR041.01	Physiology	82	80	
	MR041.05	Biochemistry	78	80	
62758N	MF51.524.005	Aviation Med	400	515	
	MF51.524.024	Physiological Assess	100	130	
63706N	M4312	A/C Impact Injury Prev	1317	1391	
			<hr/>	<hr/>	
			2027	2196	+ 8
<u>Health Care</u>					
62758N	MF51.524.021	Fleet Health Care Tech	116	411	
63706N	M4311	Medical Support Sys	869	639	
			<hr/>	<hr/>	
			985	1050	+ 7
<u>Human Performance</u>					
61153N	MR041.01	Physiology	171	160	
	MR041.05	Biochemistry	169	179	
62758N	MF51.524.002	Stress Tolerance	439	479	
	MF51.524.004	Performance Limits	428	520	
	MF51.524.022	Population Hlth Patterns	202	183	
63706N	M4305.07	Psych Screening	176	176	
	M4305.08	Physical Standards	242	242	
			<hr/>	<hr/>	
			1827	1939	+ 6
<u>Trauma Care</u>					
61153N	MR041.02	Immunology	556	550	
	MR041.05	Biochemistry	180	194	
	MR041.20.01	Clinical Medical Sci	514	522	
62758N	MF51.524.013	Tissue Preservation	162	183	
	MF51.524.016	Treat of Shock States	-	100	
63706N	M4305.05	Medical & Surg Spt	593	543	
	M4318	Trauma Care Sys	1484	1699	
			<hr/>	<hr/>	
			3489	3791	
FY74 Funds Applied			70		
			<hr/>		
			3559		+ 7

TABLE E-1 (CONT.)

<u>PE/PROJ/TASK/SHORT TITLE</u>			<u>FY75</u>	<u>FY76</u>	<u>% Change</u>
<u>Infectious Disease</u>					
61153N	MR041.05	Microbiology	494	541	
	MR041.09	Epidemiology	805	815	
62758N	MF51.524.009	Infectious Disease	1201	931	
63705N	M4305.12	Infectious Disease	374	564	
			<hr/>	<hr/>	
			2874	2851	
			190		
			3064		
			-213		
			2851		
					even
<u>Occupational Health</u>					
61153N	MR041.01	Physiology	178	165	
62758N	MF51.524.007	Ship/Amonib/Fld Med	515	-	
	MF51.524.017	Vibration	162	-	
	MF51.524.020	Hearing Conservation	63	-	
	MF51.524.023	Occupational Health	59	850	
62755N	MF57.572.001	Environmental Prot	200	217	
	MF57.572.002	Sewage Sterilization	210	227	
63705N	M4305.14	Occupational Health	-	200	
			<hr/>	<hr/>	
			1387	1659	
			35		
			1422		
					+ 16
<u>Dental Health</u>					
61153N	MR041.20.02	Clinical Dental Sci	335	338	
62758N	MF51.524.012	Preventive Dentistry	209	195	
63705N	M4305.04	Dental Equip /Practices	27	120	
	M4311.02	Dental Fld Equip	63	-	
			<hr/>	<hr/>	
			634	653	
					+ 3
<u>Other Programs</u>					
61152N	MR000	Independent Research	560	589	
64771N	M4317	Respirator	506	50	
	M4322	Suction Pump	20	-	
65152N	M9102	Studies & Analyses	100	100	
65251N	M9210	Fac & Install Spt	2229	2219	
65352N	M9920	Instr & Matl Spt	1268	3215 *	
			<hr/>	<hr/>	
			23836	27130 *	
					+ 14
			695		
			<hr/>	<hr/>	
			24531		
					+ 10

* Includes 1.743M for collateral equipment requirements in connection with EHEL Milcon project. If not included actual increase FY76 over FY75 equals 6%.

1. Operational Relevance
2. Urgency of Need
3. Return on Investment
4. Cost Benefit Ratio
5. State of the Art
6. Scientific Merit
7. Investigator Competence
8. External Level of Effort
9. Resource Availability

An additional factor unlisted with the foregoing formal criteria but nonetheless of some importance is external influences. Though lacking a specific example of the force exerted by an external influence it would be an insufficient review to not recognize the existence of external forces having some bearing upon program and project review processes. The extent to which these forces impact upon the medical R&D effort remains ill-defined. Should external forces surface as a deterrent to the NMRDC mission, they should be exposed within the authorized channels of communication.

In the area of independent pursuit of potentially promising but lesser research efforts some latitude to develop pilot projects is permitted. In contrast with earlier procedures the decision latitude to conduct short term pilot projects has been subjected to recently instituted reasonable controls. For example, all pilot projects regardless of local appeal are reviewed at NMRDC, judged with criteria

based factors of approval or disapproval, and are strictly time limited to not exceed more than two years of local effort. This precludes independent pursuit at local laboratory and activity level from escaping reasonable procedural assessment and review. As a management control this reduces potentially futile forays into non-productive efforts.

IV. Findings

The medical R&D subcomponent of the Navy Health Care System (NHCS) functions within a tightly constrained web of organizational complexity. Both managerial and functional interactions fit within established Navy recognized lines of communication, authority, guidance, and objectives setting mechanisms which extend from the ASN(R&D) to research laboratories.

As an identified subcomponent of the NHCS dedicated to relevant military unique investigation and development, the medical R&D program has clear visibility. As a subcomponent of the entire Navy RDT&E effort, it has diminished visibility since it is dwarfed by a hardware oriented RDT&E community. The implication to be drawn from this observation is simply that its smallness encourages a likelihood of overlooking its importance as an active contributor to the total RDT&E effort and mission.

SECTION VI

Health Care Resources

Section A - NHCRC Review of Military Manpower Requirements

Section B - NHCRC Review of Personnel Management of the
Health Care Community

Section C - NHCRC Review of Navy Medical Department
Fixed Facilities

Section D - NHCRC Review of Navy Health Care Facilities
Modernization Program

SECTION A

NHCRC REVIEW OF MILITARY MANPOWER REQUIREMENTS

I. Background

This section addressed problem areas and identified ongoing initiatives in the health care delivery community as related to military manpower requirements. In the context of this review, manpower requirements are considered to be those military billets that are presently funded and authorized by the CNO. This section will not address personnel, or "bodies," except in areas where the comparison of bodies to billets is required. In those cases it will be clearly identified that bodies are being addressed.

II. Discussion

The number of billets in the Medical Department (officer and enlisted) is provided in Appendix I. The numbers for fiscal year 1972-75 are the actual number of billets written as of the end of that fiscal year (e.g., 30 June 1972, 30 June 1973). The numbers for fiscal years 1976 through 1982 are proposed or forecasted figures and are based upon the following references: CNO Officer Requirements Plan, serial 104F/96175 of 10 October 1975 and CNO Enlisted Requirements Plan serial 104F/96152 of 10 September 1975.

A brief overview of how the military manpower quantity and quality is programmed into Navy activities is displayed

in Figure A-1. The Officer and Enlisted Requirements Plan is developed semiannually based upon the 30 March and 30 September billet quality information which is in support of the approved Five Year Defense Program (FYDP). A sample of the Enlisted Grade Guide pertaining to Hospital Corpsmen and Dental Technicians is provided in Table A-1. OP-104 is the action office within OP-01 for decision on all requests concerning changes between grades/designators or rates/ratings.

TABLE A-1

ENLISTED GRADE GUIDE

Ref: CNO lts ser 104C/96010 of 29 Jan 1975

	<u>Billets Authorized</u>	<u>On Board</u>	<u>Delta</u>
HMC	173	191	+18
HMCS	408	442	+34
HMC	1,794	1,731	-63
HM1	3,132	3,476	+344
HM2	4,410	4,335	-75
HM3	5,125	4,867	-258
<hr/>			
S.T.	15,042	15,042	--
<hr/>			
DTCM	20	25	+5
DTCS	52	60	+8
DTC	172	237	+65
DT1	401	475	+74
DT2	586	594	+8
DT3	832	672	-160
<hr/>			
S.T.	2,063	2,063	--
<hr/>			

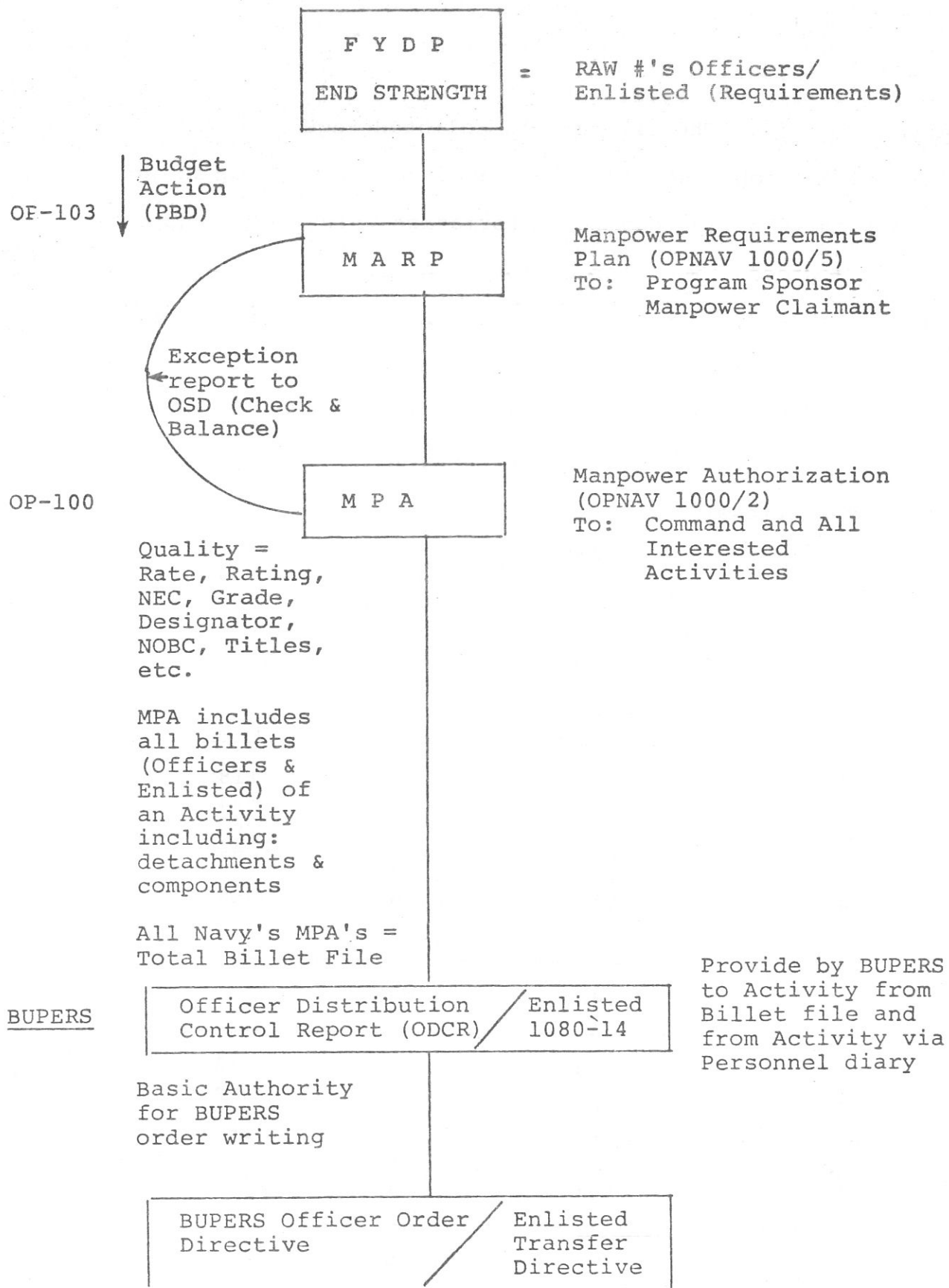


Figure A-1

FYDP - Navy authorized end strength/NO's

OP-100:

MARP 1000/5 - UIC display of the FYDP (Manpower)
- MARP Change request 1000/4A (Green copy)

MPA 1000/2 - Statement from OPNAV to activity (Copy to major claimant) - lists all officer and enlisted billets within activity

Fields:

MPA Change Request 1000/4A (Yellow copy) - Action request to OPNAV to change MPA

BUPERS 3

Billet File - Billet quality display of UIC/PE of funded billets - aggregate of latest MPA's in Navy

OP-104:

ORP/ERP - Reflects summary quality break (forecast) of manpower requirements (NO's) derived from Billet File semi-annually by paygrade/designator/rating

Figure A-1 (Cont.)

Information provided in a briefing by BUMED Code 37, described the functions of the Manpower Requirements Division of BUMED. He cited as his most paramount guidance: SECNAV Instruction 5312.10C, the Officer and Enlisted Requirements Plan, and the OPNAV 12P-6 (Manual on SHORSTAMPS). It was stated that the Officer and Enlisted Requirements Plan was a static report and was pre-empted by a more up-to-date report called the Officer/Enlisted Designator Sponsor Report (Report #R41030B and R51030B), which is revised monthly. Consequently, the later reports are employed in determining officer and enlisted manpower plans within BUMED. BUMED's specific problem areas and current initiatives are addressed separately under the appropriate section of this review.

The SHORSTAMPS program was explained by OPNAV (OP-124). SHORSTAMPS is comprised of the SHOROC subsystem of standard tasking phrases, and the Navy Staffing Standards subsystem, linked by common terminology. The synthesis of these elements is a significant improvement in requirements determination and resource management ashore achieved by foregoing a positive linkage between an operational capability and the resultant manpower requirements. A full treatment of the SHORSTAMPS methodology and its relationship to the U.S. Navy Manpower Requirements Program is found in U.S. Navy Manpower Requirements Program, Shore-Based Activities, OPNAV 12P-6.

For an understanding of the structure of the medical corps grades, Table A-2 is presented. The first column lists the billets written in the Officer Requirements Plan (ORP) at the end of FY 1975 (written on 15 Nov 1974). The second column lists the billets actually written on 30 June 1975 (ref: Officer Designator Sponsor Report (ODSR) of 30 June 1975). The third column lists the number of personnel on board as of 30 June 1975 (ref: BUPERS (Pers 211)). The fourth column lists the billets written in the ORP at the end of FY 1976 (written on 10 Oct 1975). The fifth column lists the billets written on 30 June 1976 (ODSR of 10/31/75). The sixth column lists the number of personnel on board as of 31 October 1975.

OP-121 presented an overview of the Navy Manpower system in the POM process. The importance of early identification of manpower requirements was emphasized to permit growth to fill required billets. The Navy is unique from civilian industry in that the Navy "grows" its own talent and civilian industry may recruit at all levels from without the organization. A helpful definition of the manpower requirements documentation was presented as follows:

TABLE A-2

MEDICAL CORPS GRADE STRUCTURE

	ORP End 6/30/75	BILLETS WRITTEN End 6/30/75	ON BOARD 6/30/75	ORP End 6/30/76	BILLETS WRITTEN End 6/30/76 (as of 10/31/75)	ON BOARD 10/31/75
FLAG	19	19	15	19	19	15
CAPT	315	313	432	310	308	413
CDR	411	412	484	401	399	444
LCDR	1,137	1,133	1,533	1,122	1,124	1,730
LT	1,873	1,880	967*	1,828	1,829	1,096
TOTAL	3,755	3,757	3,431	3,680	3,679	3,698

* June typically short month for medical officers because of historical exodus of junior MO's during this month. Man-year average for 1975 = 3747 (ref: Pers 211).

Ship Manning Document (SMD)

Ship at Sea at War Requirements
(unconstrained)

Manpower Authorization (MPA)

Authorized CNO funded billets
(end strength constraint)

Fleet Manning Plan Document

Five percent less than MPA
(man-year constraint)

III. Problems

A. In March 1975, a comparison of bodies with billets resulted in the following:

	<u>Billets</u>	<u>Bodies</u>	<u>Delta</u>	<u>% Staffed</u>
Total Med. Officer	3756	3778	+22	100.6
BUMED Activities	2929	3459	+530	118
Non-BUMED Activ.	827	319	-508	38.5

The above figures are displayed primarily to indicate a possible problem in distribution and not a problem of over-staffing. There are several causative factors that tend to explain this shortfall in non-BUMED activity staffing:

1. Pilot program of the single manager concept of fleet medical support, presently in process at SURFPAC and SURFLANT.

2. Utilization of Navy Medical personnel at Marine Corps FMF units from contiguous Naval Regional Medical Center.

3. BUMED activities provide direct fleet support in providing hospitalization to fleet personnel.

4. Training physicians is the life blood of the Medical Corps in regards to recruitment, retention, and keeping clinical pace with technology; significant amount of training takes place in Naval Regional Medical Center commanded by BUMED.

B. The following are problems as viewed from BUMED in connection with Manpower Requirements (reference: Captain J. Feith, Code 37, BUMED, Manpower Requirements Section, 24 July 1975 brief to Navy Health Care Review Committee).

1. As major claimant, BUMED controls only 55.13 % of Medical Department billets. BUMED must detail bodies to 100% of these billets. The Surgeon General is technically responsible for total Navy health care.

2. BUMED does get consulted concerning manpower management decisions within the OPNAV organization; however, BUMED would like to be in on the decision process affecting all reprogramming of medical assets of other manpower claimants. This evokes the responsibilities of the designator advisor.^{1/}

^{1/} The functions of the Designator Advisor are quoted from OPNAVINST 1000.16C.

"e. Officer Designator Advisors. Certain designated commanders of Navy Commands, bureau chiefs, and heads of other offices of the Navy are designated as advisors to the Chief of Naval Operations and the Chief of Naval Personnel in manpower and personnel matters involving

the various officer categories in the Navy. Officer designator advisors, as listed in enclosure (5), have the following responsibilities:

(1) As required, advise the Chief of Naval Operations, the Chief of Naval Material, and the Chief of Naval Personnel concerning matters such as personnel procurement sources, training, special education, and career development.

(2) Recommend to the Chief of Naval Operations sources of officer billet or grade compensation for changes in authorized manpower or officer grade structures.

(3) Provide to the Chief of Naval Personnel, as required, detailed officer personnel strength plans necessary for the formulation and updating of annual budgets.

(4) Advise the Chief of Naval Operations and the Chief of Naval Personnel on matters concerning the professional management of the assigned officer specialty category.

(5) Provide technical advise and assistance to the military manpower claimants and program element sponsors concerning peacetime and mobilization manpower requirements for activities in which the officer designator advisor has functional interests."

3. Commands are not reviewing MPA's. Commands are requesting bodies without first making an effort to review requirements.

4. BUMED feels that the Surgeon General has no review of the ship manning documents and therefore can make no recommendations concerning medical input. OP-124E was consulted on this issue and states that this is true. BUMED does not review SMD's. per se, however, BUMED is contacted for advice concerning designator/NEC, but not raw numbers. OP-124E recommends that the Designator Advisor does have input to SMD formulation through the issuance of documents that establish staffing criteria and drive the SMD's such as the NEC Manual, Qualification Manual, Minimum Pay Grades for Navy Enlisted Classification Manual, and the NOBC Manual.

C. To provide billet quantity for the Uniform Services University of the Health Sciences (USUHS), certain medical student accounts were decremented in January 1975 by OPNAV. The following programs were affected:

	<u>FY-77</u>	<u>78</u>	<u>79</u>	<u>80</u>
Student Medical School Scholarship	48	135	210	218
Student Senior Medical Student Program	-	-	-	10
Student Civilian Hospital Schools	-	-	-	30

The above requirements provided the below listed quantity for the student account of the USUHS (Original row).

Concurrently, Program Budget Decision #238 decremented the numbers in the USUHS to those shown in the second row (PBD 238). POM 77 action further adjusted those numbers of the USUHS to that reflected in the third row.

STUDENT - USUHS

	<u>FY-75</u>	<u>FY-76</u>	<u>FY-77</u>	<u>FY-77</u>	<u>FY-78</u>	<u>FY-79</u>	<u>FY-80</u>
ORIGINAL	0	11	26	48	135	210	258
PBD 238	0	11	26	48	85	108	135
POM 77		11	29	44	68	102	138

The Surgeon General felt that it was the intent of Congress that students of the USUHS not be counted against authorized strength.

It was not the intent of BUMED to significantly reduce the medical osteopathic scholarship program in the out/years or to decrement it in its entirety as now exists in FY 1980. Either POM action or reprogramming of other designator communities will be required to correct the shortfall in this most viable and necessary scholarship program.

IV. Current Initiatives

A. Enlisted billet structure of the medical department is considered to be ideal, i.e., a normal progression of growth from one pay grade to another is permitted in the quantity of billets for both HM's and DT's.

B. Reorganization of BUMED, specifically Code 02 (Program Planning and Analysis) will coordinate all plans and programs. Each division will no longer submit independently (e.g., NC, DC, HC, MC) plans for manpower, staffing, training, and budgeting. All POM will be coordinated through BUMED Code 02. All manpower POM and reprogramming action will be further coordinated through BUMED Code 37. This reorganization will bring BUMED totally into PPBS (CPAM/POM) process. It will ensure that programs carried out are those same programs that have approved plans as foundations. It will also give the CNO some method and criteria for evaluation of program and control.

C. The current Navy Medical Department Manning Priorities lists "Direct support of operational forces" as number one priority. It is expected that this initiative will eventually offset the billet/body mismatch addressed as a problem area in the operational forces staffing. In recent months the problem listed in paragraph III.A. above has markedly improved. The number of non-BUMED billets filled has significantly increased. Specific follow-up data on this subject can be seen in Chapter VI, Section B, the Personnel Management Section.

D. BUMED has an indoctrination program for Commanding Officers, Administrative Officers and personnel officers which includes topics on manpower management. It is felt that this program will tend to solve some of the problems addressed in paragraph III.

E. STAFFTAR (Staff Target). BUMED has initiated a study to determine requirements by specialty based upon historical and subjective analysis. This study is being accomplished in conjunction with OPNAV's (OP-124) SHORSTAMPS. The initial phase of the STAFFTAR is being performed in the orthopedics service. NAVMACLANT is assisting BUMED in some of the situation or direct observation aspects of this study.

V. Conclusions

The problems identified in this section are presently in process of being reviewed within OPNAV, BUPERS, and BUMED. Some of these problems have already been corrected to some degree. Those initiatives listed in paragraph IV are considered worthwhile and conducive to effective and efficient practices of management.

VI. Recommendations

Those initiatives identified should be continued. Efforts to resolve existing problems should be continued. The problem concerning the Medical Department billet/body mismatch (addressed in III.A.) should be monitored periodically by CNO and CNP to ensure that operational fleet units receive priority manning.

APPENDIX I

Medical Department Officer Billet Requirements

(FY 72-FY 82)

Medical Department Enlisted Billet Requirements

(FY 72-FY 82)

- (1) Hospital Corpsmen (HM)
- (2) Dental Technicians (DT)

SECTION B
NHCRC REVIEW OF PERSONNEL MANAGEMENT
OF THE
HEALTH CARE COMMUNITY

I. Introduction

The management of Navy Medical Department personnel takes place primarily within the Bureau of Naval Personnel, Bureau of Medicine and Surgery, and the Naval Recruiting Command. This section will address separately the officer and enlisted personnel of the Navy Medical Department. Additionally, when a problem area is peculiar to a specific Corps within the Medical Department (i.e., Medical, Dental, Medical Service, Nurse), that particular Corps will be addressed individually in that case. Unless otherwise stated, this section will address personnel as "bodies" opposed to "billets" or "spaces" of the manpower section.

The purpose of this section is to set forth the findings of the Navy Health Care Review Committee (NHCRC) review of briefings given by BUPERS, BUMED, and CNRC to the NHCRC describing the functions and problems of the personnel management process. The briefings were of a series designed to bring the NHCRC "up to speed" on the various aspects of the personnel resource planning, allocation, and distribution process.

II. Discussion

A. Officer Personnel Strength Planning

1. Environment. The Navy officer community strength plan development process has a number of internal and external influences that impinge upon it. These include: begin and end strengths; man year average; fiscal controls; requirements plans; procurement quotas; goals for women; minority ratios; enlisted to officer ratios; designator advisor gain/loss; and promotion data. At any given point in time, these influences are momentary constants and represent the constraints within which the plan is developed. Many of these constraints change frequently and not always predictably thus complicating the process. It is always necessary to maintain a degree of flexibility; however, as the plan is executed the capability to "adjust" rapidly diminishes. Mid or late year changes to or deviations from the plan are particularly critical.

2. Interfaces. Agents, agencies and processes interfacing with the strength plan development include the following:

a. Designator Advisors are sponsors of restricted line and staff communities which are subsets of the Navy officer community. BUMED is the Designator Advisor for the four Medical Department officer communities. Designator Advisors are responsible (in the strength planning environment) for gain/loss and promotion planning for their communities within the guidance provided by BUPERS. PERS 2 enters a "negotiation" process with the advisors for

each new or revised plan that is developed. The Navy officer strength plan (for a given fiscal year) is an aggregation of 18 Designator Advisor plans (4 of which are BUMED's) and the unrestricted line plan developed by PERS 2. The plan for one fiscal year goes through eight major planned iterations beginning approximately twelve months before the fiscal year in question. Numerous unscheduled minor revisions are made throughout this time, often as late as the third quarter. For a further discussion of the Designator Advisor function see OPNAVINST 1000.16C.

b. OP-01 develops the Officer Requirements Plan (ORP). The ORP is the "target" to which the strength plan is aimed. In practice there will always be a gap between the ORP and the strength plan. This gap is a result of gain/loss patterns and other external constraints imposed upon the process (e.g. additional guidance from higher authority and the impact of sub-optimal community goals).

c. Commander, Navy Recruiting Command (CNRC) is responsible for the actual "capturing" of all accessions within the procurement quotas generated in the strength planning process.

d. Program Objectives Memorandum (POM) development creates the initial strength and man year constraints that impinge upon the strength plan development.

e. OPNAV handles the POM process and is the source of follow-on strength, man year and fiscal guidance for strength plan updates.

Numerous other minor or occasional interfaces exist within and without the BUPERS organization which are not of significant interest to mention in this section.

It is through this network of interfaces that constraints are passed and the dynamics of the development process flow.

3. Constraints.

The major constraints in the process are the following:

a. End strength is defined as the number of officers that are authorized to be on board at the end of the fiscal year in question. End strength is received as a gross number, is broken down in PERS 2 by community and apportioned to the Designator Advisors as an input to their planning process. By OSD definition, the end strength for year X is the begin strength for year X+1.

b. Man Year Average (MYA) is a gross Navy officer number received by BUPERS from OPNAV, broken down by PERS 2 and apportioned to the Designator Advisors as inputs to their planning processes. This apportionment occurs with each major planning iteration. The MYA is an

average on board number that equates more to dollars than strength. The MYA is what has to be paid a salary.

c. Dollars are assigned by Congress through the MPN account. Dollars have a major and direct impact on MYA trade-offs.

d. Control Grade Ceilings are the imposed ceilings on the number of officers in each grade of 04 and above. These ceilings are imposed by Congress through the budgetary process and represent the maximum control grade strengths. Recently, overall Navy ceilings have been imposed for the entire last quarter of the fiscal year. These ceilings include the Medical Department communities although Medical/Dental Corps promotions are controlled by OSD and Navy can only monitor and react but not control the Medical/Dental numbers in grade.

Following this initial development, there are periodic, scheduled updates that are in response to guidance updates. The second of these updates (third plan) becomes the congressional submit (President's Budget) about six to seven months prior to the fiscal year in question. These follow-on updates are made through Designator Advisor action in response to PERS 2 guidance.

Interspersed throughout this same time are numerous unscheduled changes which may be initiated by either PERS 2 or the Designator Advisors. Unscheduled changes may affect all or only some of the communities.

Each of these changes requires a formal "negotiation" process to resolve. Changes are initiated as a result of revised gain/loss data, changes in manning requirements, policy decisions, force reductions, etc.

It is the Designator Advisor's responsibility to maintain his plan in a current, accurate status. Prior to execution, this means updating whenever loss patterns, etc. change and formally communicating the variances to PERS 2 in order that impacts on policy and other communities be properly assessed within current guidance. During execution of the fiscal year in question, it is imperative that plan implementation be as accurate as possible. This requires close monitoring by the Designator Advisors.

e. Some other pressures that currently exist are:

(1) Reduction in the total number of senior officers.

(2) Increasing the tooth to tail ratio (URL:non URL) to the current goal of approximately 59%.

(3) Decreasing the total number of Navy officers compared to Navy enlisteds (thus changing the ratio from the current 1:7.5 to the planned 1:7.6 for FY 80).

(4) Goals for numbers of minorities, women, etc.

4. Process. The definitive planning process, for a given fiscal year, begins about 18 months in advance

(in actuality, the plan has already been grossly addressed for three years in the FYDP updates) with the MPN portion of the POM cycle.

Following an initial round of negotiations, the POM process outputs the initial end strength, MYA and dollar guidance. Subsets of the end strength guidance are distributed to the Designator Advisors who then generate strength plans for their respective communities. The community plans are submitted to PERS 2 for review and reconciliation of differences from guidance. All the plans are then aggregated into a total Navy plan (by pay grade). This is completed about 12 months in advance of the fiscal year in question. It must be recognized that any change in one community plan (either end strength or MYA) requires a corresponding adjustment in some other community (usually URL) given that the overall Navy guidance has not changed. Having the closest liaison with their respective communities means that the Designator Advisors normally have gain/loss and promotion information much sooner than the Officer Master File from which PERS 2 receives its information and therefore the designator advisors are the earliest source of deviation information.

An over strength condition at the end of the year is in violation of the law as an over expenditure (MYA) and culpability may be assigned. An understrength condition has implications in reducing credibility with OSD/Congress

and producing strength and/or fund reductions for the following year. Either excess losses or a shortfall in gains (producing an understrength condition) have a repercussion in later years in a reduced RAD (release from active duty) base and in reduced year groups to maintain a balanced career force. These, and numerous other less significant problems, are directly attributable to inaccurate or inadequate planning because data is insufficient and/or the monitoring and execution of plans is less than optimal.

To illustrate the impact of these planning shortfalls, there was an FY 76 begin strength deficit of 375 between the FY 76C plan (President's Budget) and the FY 76F plan which was the first FY 76 plan to incorporate actual vice planned begin strength. In light of this deficit, it is significant to note that the Medical Corps alone had an FY 76 begin strength shortfall of 496.

During the eight years 69-77, the total Navy officer force will complete a 20,000 reduction to just over 63,000 (Figure B-1 shows the last five years 72-77). Figure B-2 shows the required accessions (solid line) to maintain the intermediate strength levels and the actual accessions (dotted line) experienced. The final requirement figure of 7,300 is the projected accession level to support a 63,000 officer force in the out years (Figure B-3 shows end strength through FY 81). The accession shortfall is a result of end strength reducing

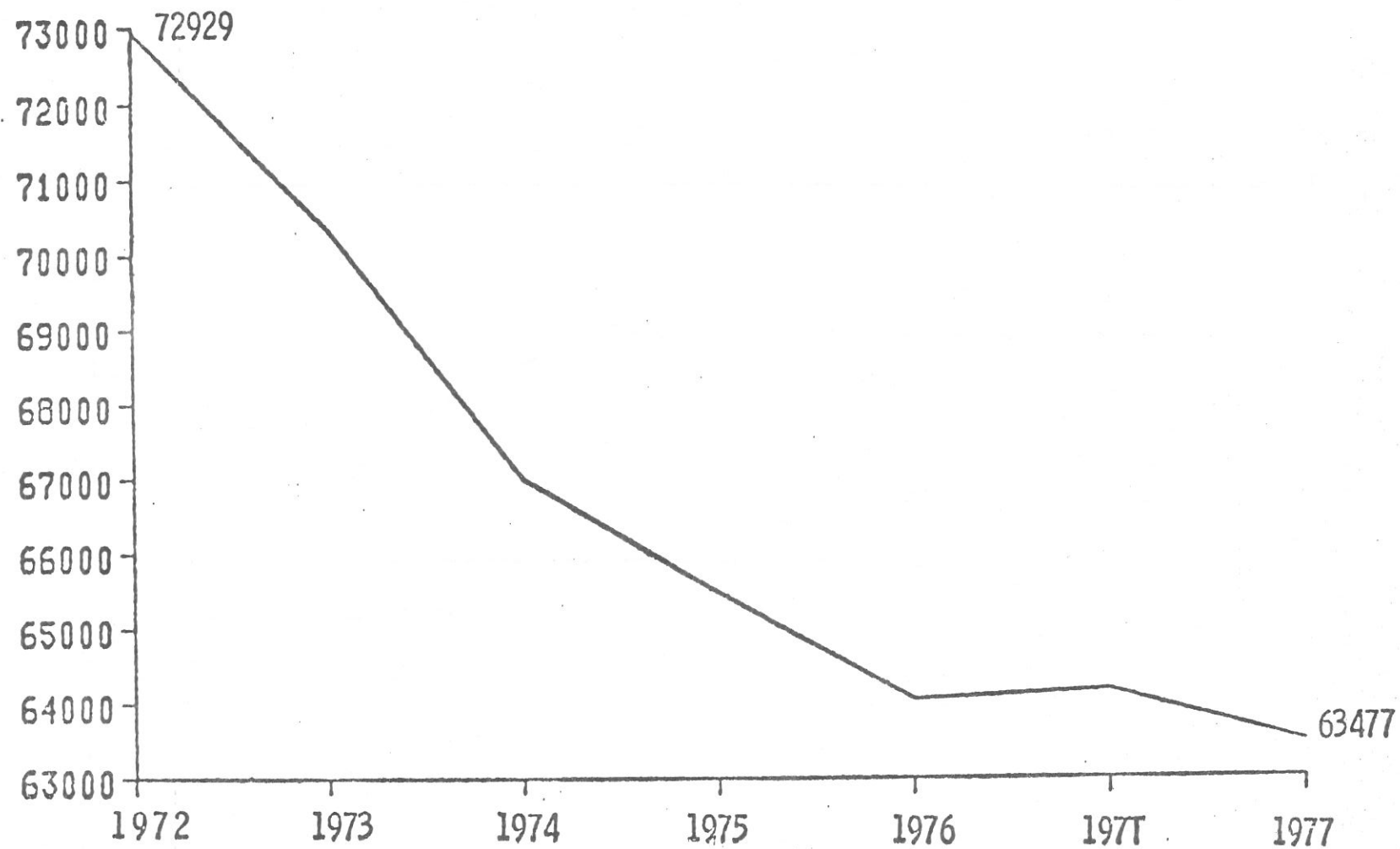


Figure B-1

OFFICER FORCE FY 72 - FY 77

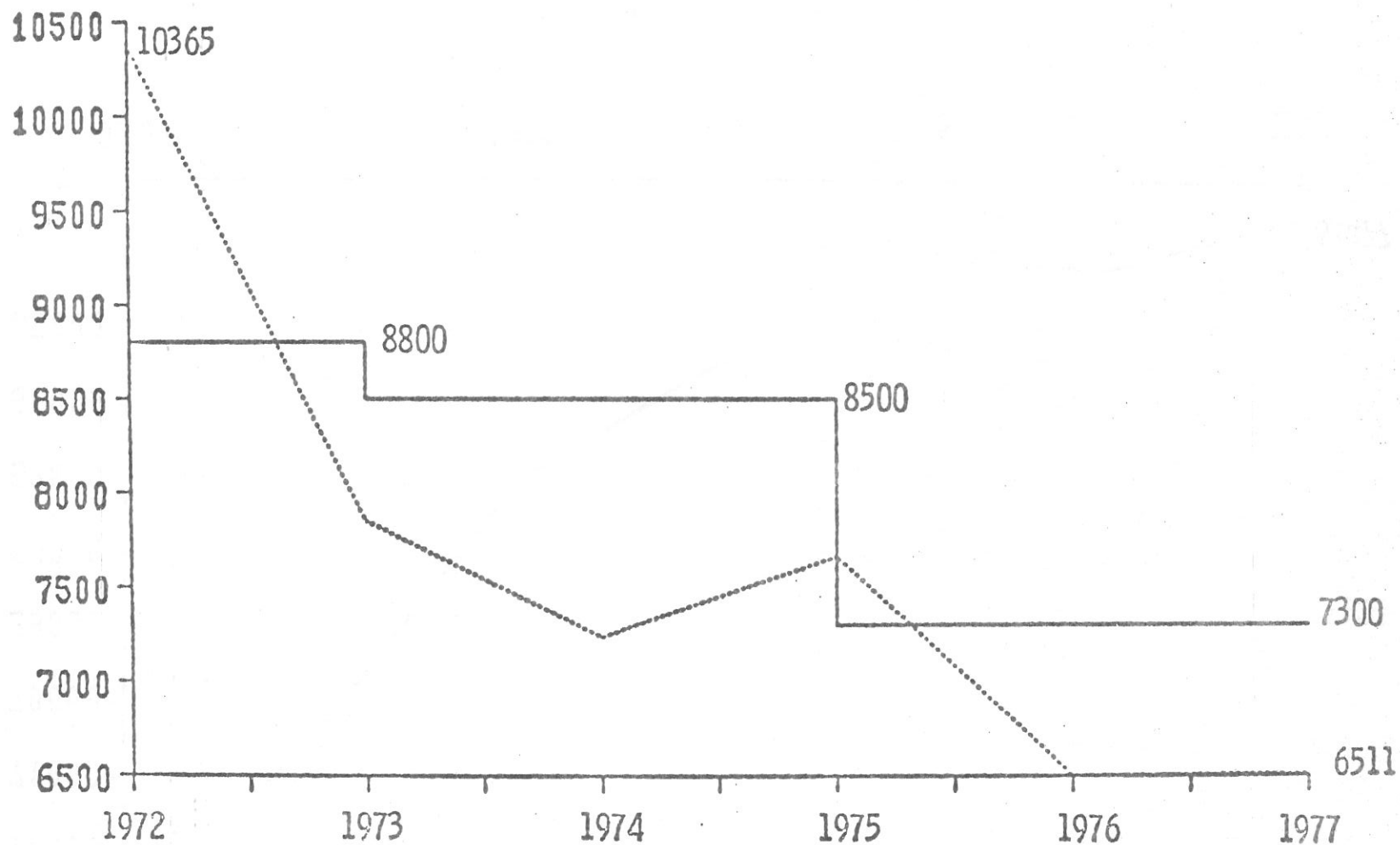


Figure B-2

ACCESSION REQUIREMENTS VS ACCESSIONS FY 72 - FY 77



Figure B-3

PROJECTED OFFICER FORCE FY 77 - FY 81

actions in an attempt to avoid involuntary losses. The effect is seen in Figure B-4. Current reduced accession levels are seriously eroding the RAD base (available losses) for the outyears, thus the outyear accessions will also require reduction as shown. This is a circular problem that works itself out rather slowly and, in the process, generates a top heavy force structure. It is incumbent upon the process of formal negotiation and information exchange (PERS 2 and the Designator Advisors) to insure that this longer term issue remains visible during short range decision cycles.

Figure B-5 is a display of billet reductions for the period 69-77 showing the erosion of non-medical department billets as 27.16% compared to an all medical department officer billet decline of 6.1% (Medical Corps declined for this period was 16.1%). This tends to aggravate the rising cost of medical resources and complicates the need for increasingly efficient resource management and utilization as it affects the total officer community.

Another planning area that has intercommunity impact is that of promotions and **control** grade (04 and above) ceilings. As defined earlier, these ceilings include the Medical/Dental Corps although the Medical/Dental Corps promotion process is not within Navy control (OSD controlled). If the Medical/Dental Corps is over strength in the control grades, compensatory reductions in the remaining Navy

I-209

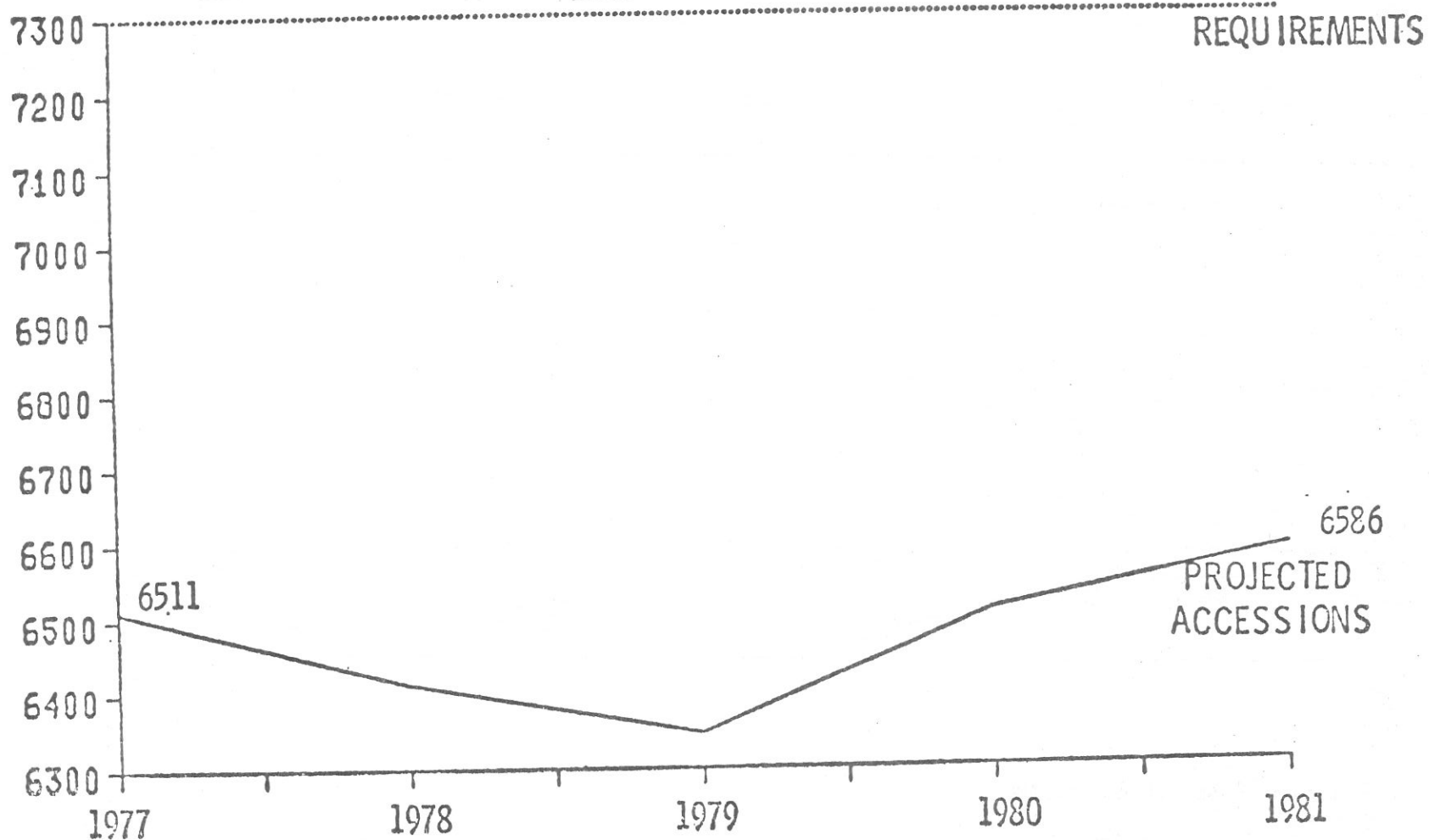


Figure B-4
ACCESSION REQUIREMENTS VS ACCESSIONS
FY 77 - FY 81

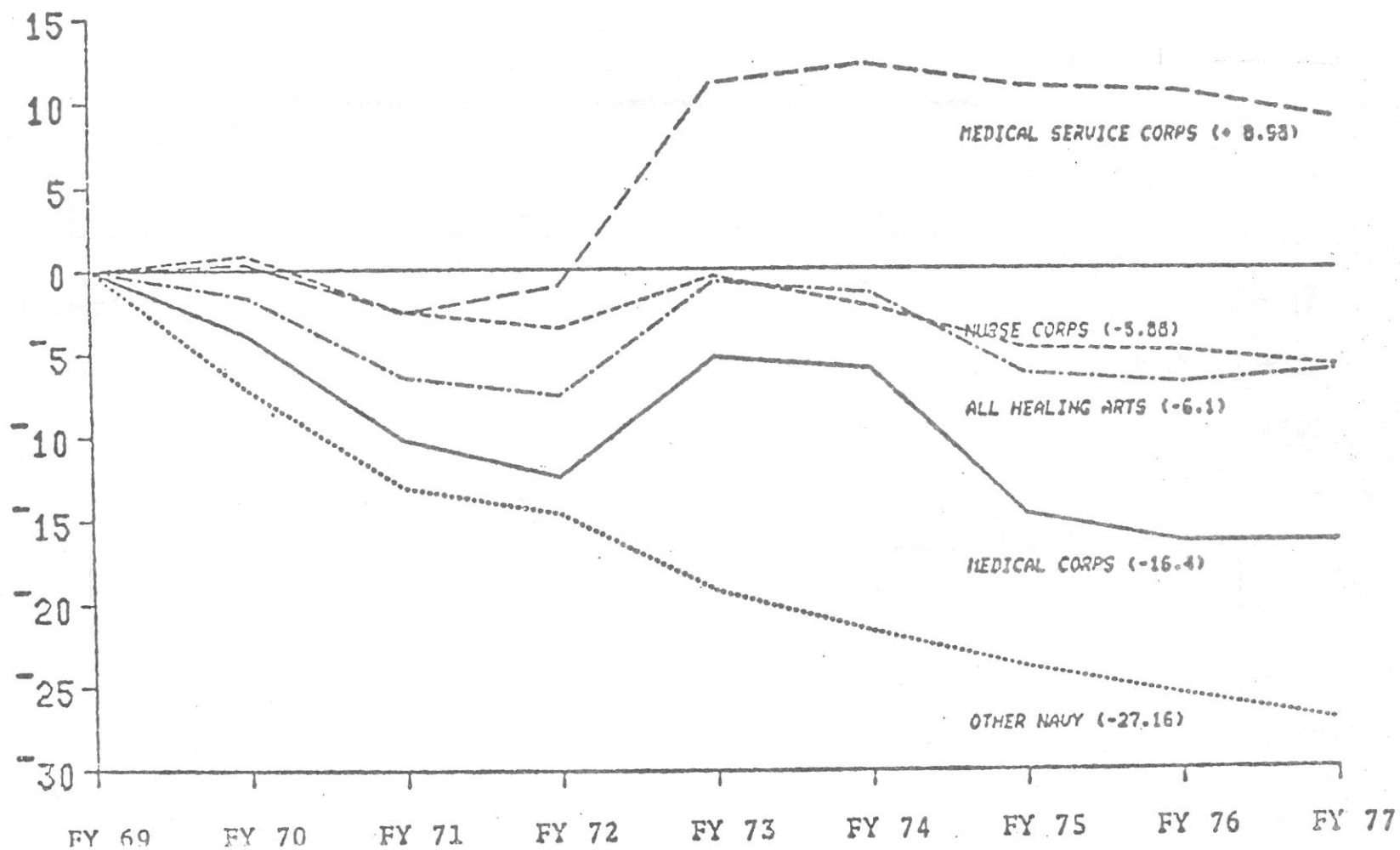


Figure B-5
BILLET REDUCTIONS (·/·) FY 69 - FY 77

officer community must occur. Table B-1 shows the recent history of Medical Corps promotions. As can be seen, they were extremely heavy in the 04 grade. This reflects in large measure the procurement of officers at the 03 level who are eligible for almost immediate (and automatic) promotion to 04, the result of current legislative guidance on Medical Corps promotion eligibility. This same situation occurs in the higher grades as well but to a lesser degree.

Until this year and since end FY 73, Congress imposed ceilings on control grades that could not be exceeded at any point in time from 1 April to 30 June. Having an unpredictable growth in promotions requires some sort of hedge to insure the ceilings are not exceeded and that hedge represents further reductions in non-medical control grades. The growth can be seen historically on Figure B-6. Medical/Dental Corps strength will decrease 1.5% over the five year period ending with FY 77 while their control grades will increase 24% during the same period. Non Medical/Dental Corps strength will decline 14% while their control grade numbers will decline 17%. The 3% additional decline of the "other" Navy control grades over end strength is largely attributable to offsets for the Medical/Dental Corps growth

It is significant to note the accession/loss pattern that is experienced by the Medical Corps. This is

TABLE B-1

MC PROMOTION PLANS VS. ACTUAL

<u>FY 74</u>	<u>PLAN</u>	<u>ACTUAL</u>	
CAPT	60	43	- 17
CDR	104	144	+ 40
LCDR	578	767	+189
<u>FY 75 THRU FEB</u>	<u>PLAN</u>	<u>ACTUAL</u>	
CAPT	19	7	- 12
CDR	22	7	- 15
LCDR	51	308	+257

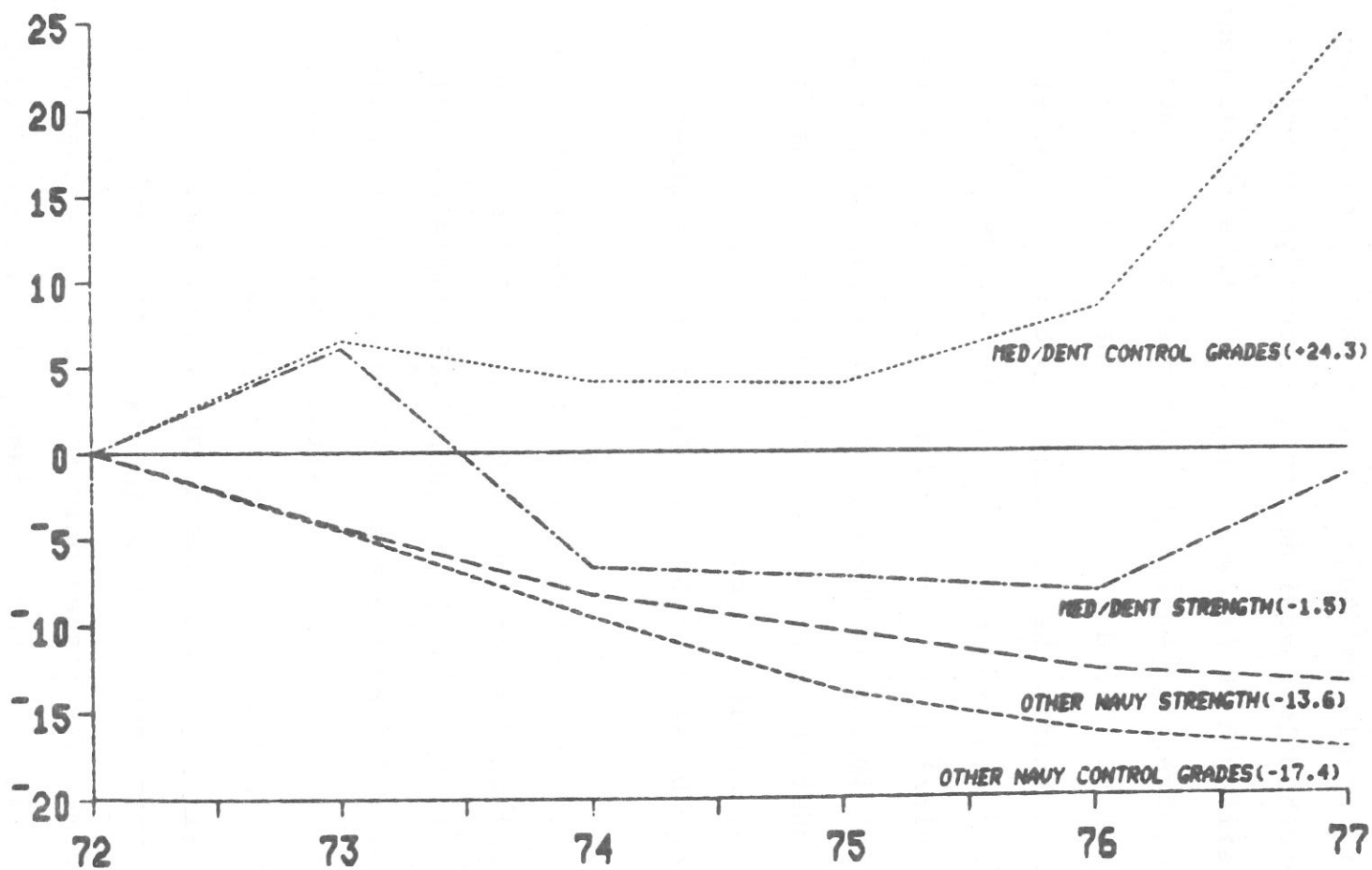


FIGURE B-6

PERCENTAGE CHANGE
CONTROL GRADES AND STRENGTH

depicted on Figure B-7. There has historically been an unavoidable and dramatic exodus in June followed by a large input in July and August. This pattern has placed the end strength below requirements in recent years while the average strength (MYA), which ran well above requirements in the early years, is generally at or just slightly above requirements in FY 75 and FY 76. Note that as a result of the fiscal year shift, the June-July dip comes at the end of the new third quarter beginning in FY 77. Should the traditional gain/loss pattern persist, this will continue to have a major impact on the Medical Corps MYA because the end strength must be at or below requirements and the dip is no longer available to get there.

B. Medical Department Officer Detailing Assignment Process.

Responsibility for the detailing function has gone through several shifts between BUMED and BUPERS over the years. Prior to the mid 1940s, BUMED had complete control of the process. During the 40s, BUMED continued to write PCS orders with info to BUPERS. After increasing involvement by BUPERS, BUMED again assumed complete control in the late 60s although there was no specific authorization to do so. A 1973 OPNAV instruction (as well as Navy Regs) stated that BUMED was tasked only to advise and recommend in assignment matters. BUMED in fact continued to control assignments by default as their recommendations were generally accepted and unchallenged. BUPERS exercised

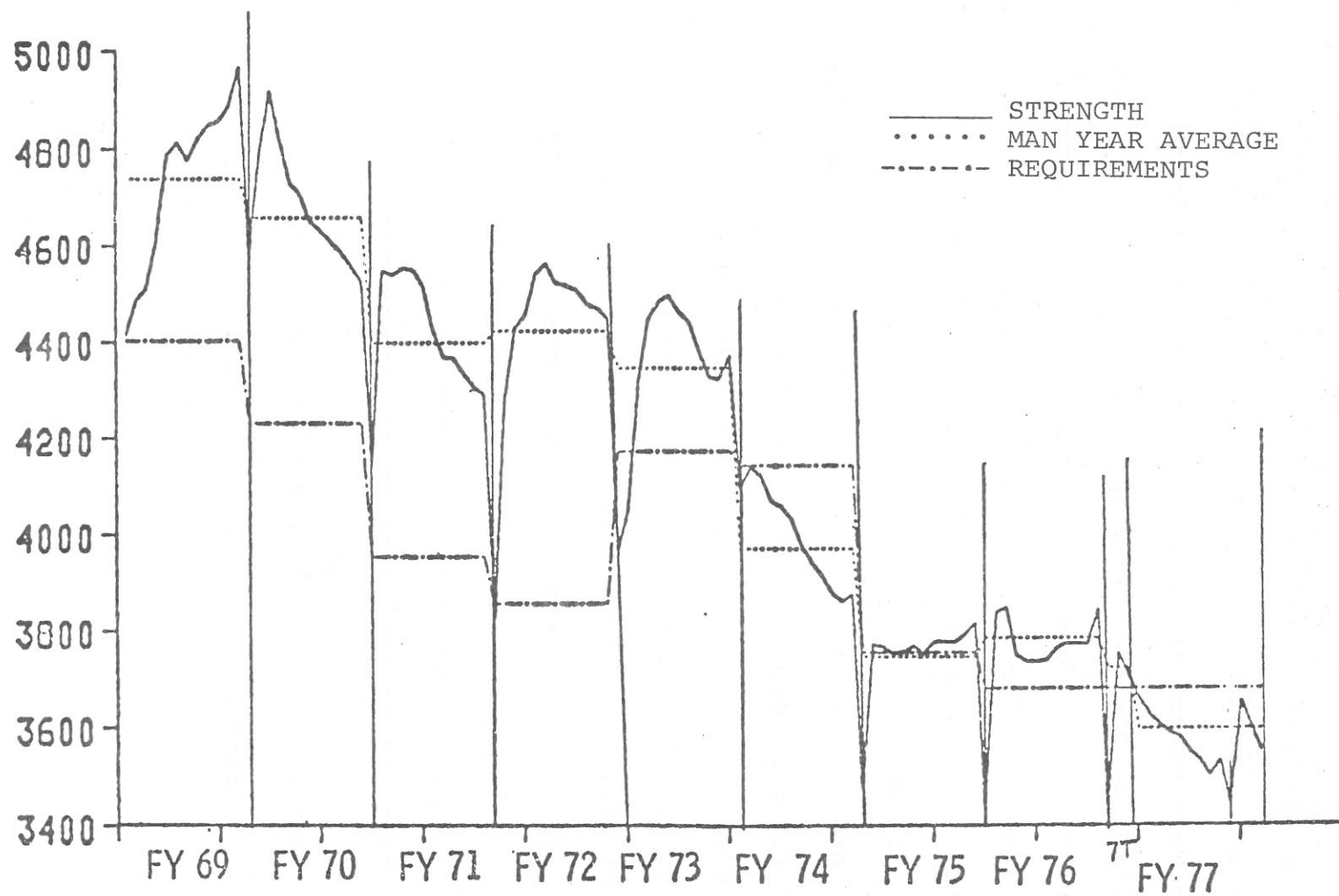


Figure B-7

MEDICAL CORPS STRENGTH/MYA/REQUIREMENTS COMPARISON

limited control until the fall of 1974 when a BUMED/PERS 4415 meeting was held to resolve the matters of billet/body mismatches and gapped Fleet billets while BUMED controlled activities were manned in excess of authorized billets.

Following the 1974 meeting, a positive move has been taken to bring billets and bodies into line. One aspect is a hard line on a "no billet - no body" approach to assignments. It was determined by BUPERS and BUMED, in order to minimize the PCS dollar impact, to align billets and bodies progressively through controls exercised during the normal rotation process. This realignment should be complete by early FY 77. At end March 1975, there were 508 unfilled non-BUMED activity billets 284 of which were gapped Fleet billets. (See Table B-2) This has been reduced to 185 fleet billets as of end August 1975, 121 of which are FMF billets for units in garrison which are not filled. There is no existing authority to leave the FMF in-garrison Medical Officer billets vacant.

TABLE B-2
NON-BUMED ACTIVITIES MEDICAL OFFICERS

	<u>Billets</u>	<u>Bodies</u>	<u>Delta</u>	<u>% Staffed</u>
March 1975	827	319	-508	38.5
August 1975	880	623	-257	70.8
September 1975	891	627	-264	70.4

The major shortages as of September 1975 were in the operating forces as FMF (121 billets) and flight surgeon (63 billets) shortfalls. By accelerating several recruitment, training and transfer programs, the Surgeon General feels that the total solution to this problem is in sight before FY 78. These efforts include:

1. Reassign now 20 flight surgeons in BUMED activities to operational billets.

2. Supplementation of flight surgeon volunteers with output from the new four week course for Aviation Medical Officers.

3. Assign HR2 scholarship accessions to operational medical billets immediately following internship.

4. Identify and fill all authorized non-contingency FMF billets.

5. Supplement operational medical officers with physician assistants.

A major contributor to the gapped billet problem was the use of 99990 on order nominations for the Billet Sequence Code (BSC). The 99990 code means "in excess" and was intended for use in those cases where relief overlap type problems arose. It was never intended to be used in order to avoid the trouble of detailing by BSC. Excessive use of 99990 by BUMED (and allowed by BUPERS) masked the gapped billet problem until it grew to

excessive proportions (greater than 200 per month in first half of 1975). It should be noted that this problem exists to some degree in all communities; however, BUMED, with 1/6 of the officer force, had 1/3 of all 99990s.

C. Medical Corps

The Medical Corps Division of BUMED has two functional responsibilities; professional matters and personnel actions and issues. The latter includes tasks such as assignment, career management and other administrative responsibilities. This Division acts as designator advisor to BUPERS/OP-01 on matters concerning designator 21XX. For a description of this responsibility see the discussions under Officer Strength Planning.

The Medical Corps is presently (end August 1975) composed of two-thirds USNR and one-third USN. The USNR officers are heavily concentrated in the grades of 03 and 04. This is a normal distribution indicating a parallel between augmentation and career orientation (See Table B-3).

Table B-4 is a breakout of the specialty mix. It is of interest that General Medical Officers (GMO), exclusive of Flight Surgeons and Undersea Medical Officers, represent only about 10% of the force and that medical Officers in Graduate Medical Education represent about 25% of the force. It is generally not fully appreciated that Medical Officer trainees in GME devote in excess of 50%

TABLE B-3
MEDICAL CORPS GRADE-STATUS PROFILE*

	Numerical Distribution				Percentage Distribution			
	2100	2103	2105	Total	2100	2103	2105	Total
VADM	1	0	0	1	00.02	-	-	00.02
RADM	13	0	1	14	00.34	-	00.02	00.36
CAPT	403	1	28	432	10.56	0.02	00.73	11.31
CDR	388	0	90	478	10.17	-	2.36	12.53
LCDR	369	0	1197	1566	9.67	-	31.38	41.05
LT	53	0	1270	1323	1.39	-	33.3	34.69
TOTALS	1227	1	2586	3814	32%	-	68%	100%

*As of August 31, 1975
Figures rounded

TABLE B-4

MEDICAL CORPS SPECIALTY MIX

	<u>General</u>	<u>Sub-Spec.</u>	<u>Total</u>
1. GENERAL MEDICAL OFFICER (GMO)	377	0	377
2. INTERNAL MEDICINE	184	228	412
3. SURGERY	174	69	243
4. ORTHOPEDICS	131	0	131
5. NEURO-SURGERY	28	0	28
6. NEUROLOGY	42	0	42
7. UROLOGY	47	0	47
8. ANESTHESIOLOGY	126	0	126
9. RADIOLOGY	137	7	144
10. PATHOLOGY	40	61	101
11. OPHTHALMOLOGY	77	2	79
12. ENT	77	0	77
13. FAMILY PRACTICE	107	0	107
14. OB-GYN	173	8	181
15. PEDIATRICS	201	17	218
16. PSYCHIATRY	163	0	163
17. DERMATOLOGY	66	0	66
18. PHYSICAL MEDICINE	9	0	9
19. OCC/PREVENTIVE/TROPICAL MEDICINE	45	0	45
20. FLT SURGEON/AEROSPACE MEDICINE	131	57	188
21. SUBMARINE MEDICINE	35	3	38
22. E.R. SPECIALIST	1	0	1
23. MEDICAL RESEARCH OFFICER (MRO)	2	0	2
24. UNCLASSIFIED (NEW ACCESSION)	1	0	1
25. GRADUATE MEDICAL EDUCATION (GME)	0	988	988
TOTALS	2374	1440	3814

of their time to direct patient care processes. Thus, they are not 100% engaged in full time education as in the case of other officer community members who are similarly engaged.

Medical Corps procurement is shifting away from dependence upon the draft driven Berry Plan. This source, in effect, will be depleted by the end of FY 77. The outlook for Medical Corps direct physician recruitment procurement, in the light of the Berry Plan loss, is cautiously optimistic. The physician recruitment ratio of applicants to quotas for FY 75 and FY 76 has been about 2.8. The principal source of physician procurement is the Armed Forces Health Professions Scholarship Program, PL 92-426.

Because retention has a direct impact on procurement requirements, it is anticipated that the procurement picture will have a direct relation to the full impact of the Variable Incentive Pay (VIP). Of the 1513 contracts offered in FY 75, 89% were accepted (See Table B-5). It is interesting to note that 463 contracts accepted were for four years and that 410 of these were officers above the grade of 04 (Table B-6). One year contracts accounted for 45% (Table B-5) of the acceptance indicating a "wait and see" attitude on the part of officers desiring to keep all their options open. As of this writing, the evidence pertaining to VIP impact is not yet available. Thus, reliable projections cannot be offered.

TABLE B-5

VARIABLE INCENTIVE PAY CONTRACTS OFFERED

Contracts Offered: 1513

	<u>Contracts Accepted</u>	<u>Percentage Accepted</u>
Total:	1348	89%
Distribution by Obligation:		
1 Year	606	45%
2 Years	220	16%
3 Years	59	4%
4 Years	463	35%

Impact of VIP on Retention

FY-75 Medical Corps End Strength

As Projected: 3100

Actual: 3426Favorable Variance 326

FULL/PARTIAL VIP CONTRACTS (FY 75)

FULL VIP CONTRACTS (FY-75)

CONTRACT OBLIGATION	GRADE				TOTAL	
	06	05	04	03	CONTRACTS	COST
1 YEAR	102	71	81	25	279	\$ 3,169,500.00
2 YEARS	56	37	52	37	182	2,175,000.00
3 YEARS	40	7	4	0	51	596,200.00
4 YEARS	200	208	46	3	457	5,760,500.00
TOTAL:	398	323	183	65	969	\$11,701,200.00

PARTIAL VIP CONTRACTS (FY-75)

CONTRACT OBLIGATION	GRADE				TOTAL	
	06	05	04	03	CONTRACTS	COST
1 YEAR	11	89	227	0	327	\$ 2,943,000.00
2 YEARS	0	3	35	0	38	342,000.00
3 YEARS	0	1	7	0	8	72,000.00
4 YEARS	0	2	4	0	6	54,000.00
TOTAL:	11	95	273	0	379	\$ 3,411,000.00

The main area of current concern in the utilization of medical officers is the shortfall in the filling of fleet medical billets. While the BUMED managed hospital facilities are overstaffed (in respect to billets), the vacancies appear mainly in aviation medicine and Marine billets. There are several reasons for this shortfall. The GMO/flight surgeon/submarine medical officer population has steadily declined in recent years from 40% of the force in FY 73 to 17% in FY 76 (Table B-7). This represents a 62.5% decrease while the Medical Corps as a whole has declined only 11.4%. This reflects the increasing medical community (civilian and military) emphasis on specialization, a problem whose short and intermediate range solutions are difficult at best. Additional complicating reasons for the fleet manning shortfall include the current unavoidable trend for virtually all physicians to pursue uninterrupted GME and specialization. This is a national social phenomenon not directly subject to Navy control. This perpetuates the GMO problem. Further, most physicians subscribe to the philosophy that a physician must practice his professional specialty regularly and with minimal interruption to maintain proficiency, currency, and morale. Considering the complex nature of medical school curricula and the civilian objectives of medical education, hard historical evidence supports the observation that medical education objectives are incompatible with GMO performance

TABLE B-7

GENERAL MEDICAL OFFICERS, FLIGHT SURGEONS, AND
SUBMARINE MEDICAL OFFICERS

	<u>FY-73</u>	<u>FY-74</u>	<u>FY-75</u>	<u>FY-76</u>
A. TOTAL 2100 COMMUNITY:	4345	3971	3836	3848
B. GMO's*:	1752	1125	708	657
C. CMO/TOTAL MC RATIO:	40%	28%	18%	17%

*GMO's: GENERAL MEDICAL OFFICERS + FLIGHT SURGEONS +
SUBMARINE MEDICAL OFFICERS

A. DECREASE IN TOTAL 2100 COMMUNITY:	<u>11.4%</u>
B. DECREASE IN GMO's:	<u>62.5%</u>

responsibilities and objectives. Thus the spectre of malutilization as perceived by both generalists and specialists constitutes a real problem of recruitment, retention, and professional satisfaction. The solutions will not be easy in forthcoming years.

In their attempt to address this shortfall problem, BUMED is actively engaged in the following efforts:

1. A hard line is being taken on "no billet - no body" in the assignment process. This effort should virtually eliminate the manning imbalance within the next 12 months.

2. BUMED has recently limited entry of Naval first year GME trainees to no more than 50% of available positions

at advanced year GME levels. The objective of this strategy is to increase the number of medical officers available for operational billet manning.

3. An emphasis is being made on the importance of the single manager fleet pool concept with consideration being made as to the extension of the three month sea tours to full cruise tours. It is felt in BUMED that success of the pooling concept is essential to preservation of acceptable levels of health care required for its complete range of beneficiaries. It should be noted here that the pool concept is considered unacceptable by the Fleets.

4. There is a current plan of employing Physician Assistants (PA) in some fleet billets (not on independent duty). As an example, replacing the two physicians on a sub tender with one physician and one PA. It should be noted that there is some doubt as to the survival of the PA program.

5. An increased emphasis is being made on the recruitment of Flight Surgeons and a recently inaugurated aviation medical officer program shows promise in alleviating the problem of flight surgeon billet manning shortfalls. This effort includes some significant pressure on individuals to enter this and the GMO field.

6. BUMED is currently in the process of non-disruptively transferring the Flight Surgeons at their Regional Medical Centers to fleet operational billets.

This requires, in many cases, only a paperwork shift but it places them under the control of operational commanders.

Another area of current concern is in Medical Corps personnel management. Several problems exist:

1. Analysis of BUMED managed activities has reflected a billet body imbalance resulting from both a specialty training emphasis and from a large total beneficiary demand for services. One solution lies in the current BUMED effort to update the NOBC Manual and to properly realign the billets. BUMED is also thoroughly analyzing their specialty training in order to develop a balance of written requirements with services demanded.

2. Strength planning has been cursory with little prior effort in understanding the necessity to adhere to a strength plan as a control document. Current initiatives have reversed this process. All indications are that close control and monitoring of the planning and execution processes will prevail in the future.

3. Assignment and distribution of personnel resources has not followed prescribed guidelines resulting in some of the billet/body mismatches described above (see also section on Distribution). Several options are now under consideration for functional reorganization of the placement and detailing responsibilities. These include consolidation and relocation in either BUMED or BUPERS.

D. Dental Corps

The Dental Division is responsible for study planning and direction of matters relating to dentistry including initiating and recommending action pertaining to allowances, appointments, advancement, training assignment, and transfer of dental personnel.

Procurement for dental programs, which is driven by authorized billet requirements, is charged to the Navy Recruiting Command, interfacing with the Dental Division, District Dental Officers and Dental School Liaison Officers.

Procurement is from four programs. The major sources in the past several years and in the projected out-years are the Armed Forces Health Professions Scholarship and the Early Commissioning Programs.

No problems in filling allocations with the Armed Forces Health Professions Scholarship Program have been experienced and none are expected. An expected decline of student interest in absence of the draft has been noted in the Early Commissioning 1925I Program which is non-subsidized. No shortfall in dental officer accessions has been experienced and none is projected for FY 76. A shortfall is projected in FY 77 based on known assets; however, with continuing active duty incentives and vigorous recruiting practices this shortfall should be averted.

Continuation pay was granted to dental officers commencing in September 1973. The influence of continuation pay may be assessed in several ways:

1. By comparing MYA/USN/USNR strength - there has been a 6.7% total increase in USN dental officers from FY 71 to FY 75 (see Table B-8).

2. By comparing Dental Corps USN gains and losses - in FY 70 there were 91 more losses than gains; however, by FY 75 there were 31 more gains than losses (see Table B-9).

3. By noting Dental Corps USN LTs vs USNR LTs on active duty - on 30 June 1970, there were only 77 USN LTs on active duty but by 30 June 1974, utilizing numbers adjusted in relation to accelerated promotions, the situation had improved by 274% to a total of 211 USN LTs on-board (see Table B-10).

4. By noting retention, as calculated by the number of officers on-board at the four year point, as compared with the total number gained four years earlier - the retention rate which may be noted in the FY percent retention column on the right of Table B-11 has improved 7.3% from FY70 to FY75.

Indications are that co-pay is resulting in increased retention of junior officers.

Dental officer specialty requirements are presently being met predominantly from in-house assets with training programs driven by NOBC requirements. Future training

TABLE B-8

CAREER FORCE TRENDS 220X

	MYA	MYA	MYA		
<u>FY</u>	<u>TOTAL</u>	<u>USN</u>	<u>USNR</u>	<u>% USN</u>	<u>% USNR</u>
71	1834	899	935	49.0	61.0
72	1789	927	862	51.8	48.2
73	1841	950	891	51.6	48.4
74	1797	966	831	53.8	46.2
75	1755	978	777	55.7	44.3

TABLE B-9

USN GAINS VERSUS LOSSES 220X

FY 70	-91
FY 71	- 6
FY 72	24
FY 73	20
FY 74	28
FY 75	31

TABLE B-10
LT DENTAL CORPS USN/USNR STRENGTH TRENDS

	<u>USN/USNR</u>	<u>%</u>
30 JUN 70	77/852	9.0
30 JUN 71	87/779	11.2
30 JUN 72	163/703	23.2
30 JUN 73	183/848	21.6
20 JAN 74	220/794	27.7
30 JUN 74	211/740	28.5*

*Including 115 O-3 USN promoted to O-4 under provisions of DOD Directive 1320.7 of August 7, 1970 and approved for Dental Officers 26 September 1973

TABLE B-11

220X RETENTION

<u>FY GAINS</u>	<u>4 YEAR ON BOARD PT.</u>	<u>FY % RETENTION</u>
66 - 468	31	70 - 6.6
67 - 425	37	71 - 8.7
68 - 502	45	72 - 9.0
69 - 491	54	73 - 10.9
70 - 480	44	74 - 9.2
71 - 394	55	75 - 13.9
<hr/>		
72 - 440	70	15.9*
73 - 488	90	18.4#

*Personnel who have completed 3 years of activeduty

Personnel who have completed 2 years of activeduty

will be predicated as in the past on billet requirements relative to available resources. Approximately 6.6% of total Dental Corps strength is enrolled in all types of training of one year or longer duration.

Some aspects of enlisted training requirements are monitored in the Dental Division and standards for entrance into the DT rating and DT "C" courses are established in the Dental Division. A plan of action with milestones for the conversion to task-based curricula of all courses in the School of Dental Assisting and Technology is being implemented and is tracking on schedule.

Enlisted billet requirements for BUMED managed activities are determined in the Dental Division and recommendations made to OPNAV. For other major claimants, the Dental Division has the responsibility for acting as technical advisor on matters regarding DT enlisted requirements.

E. Medical Service Corps

The Medical Service Corps (MSC) composition is comprised of six major sections:

	<u>Billets (9/1/75)</u>	<u>% of Corps</u>
Health Care Administration	970	53
Allied Sciences	492	27
Medical Specialist	105	06
Pharmacy	107	06
Optometry	135	07
Podiatry	15	01

The number of Health Care Administration (HCA) billets has reduced in recent years from about 65% as other sections of the MSC increased. This is a reflection of added emphasis in both direct patient care related functions.

The Allied Sciences section contains 23 separate specialties which demonstrates the diverse nature of the MSC. In order to properly manage a community of such diverse background and education, it is necessary to employ a system of "specialty advisors." Currently there are 16 such advisors who are assigned on an Additional Duty basis to afford BUMED their counsel on the various technical data necessary to make a prudent decision concerning procurement, assignment, and training.

In the past BUMED has experienced some recruiting problems with MSC officers and with a shift to an all-volunteer force they have modified some programs to provide monetary incentives. At present, future procurement of fully qualified officers looks promising in all areas.

The Annual Inservice Procurement Program provides a major input into the administrative group. This is an extremely competitive program through which outstanding senior hospital corpsmen and dental technicians have an opportunity for advancement to commissioned grade. The program also provides the MSC with young officers having prior experience in the health care field. Current planning contemplates that about 35% of the requirements for the HCA Section will come from this source.

The Direct Appointment Program provides for appointment directly from civilian life with a short orientation course immediately after appointment. Direct appointments are made in all specialties. Officers procured under this program are qualified, ready to go to work, professionals.

The Ensign, 1935, Action Program is an early commissioning student program. This program permits BUMED to commission a student who is working toward a degree (undergraduate or graduate) in health care administration, physical therapy, occupational therapy, or dietetics up to two years before graduation. This appears to have solved procurement problems in those specialties and should form the nucleus of a career motivated group.

The Health Professions Scholarship Program for the MSC is the same program as for physicians and dentists. DOD has limited this program to only three specialties in the MSC: Optometry, Clinical Psychology and Podiatry. This has proved to be a successful program and has met the input requirements for the specialties concerned through FY-1975.

NEDEP is a very small, highly competitive input program which provides an opportunity for enlisted personnel of any rating to complete college training and qualify for a commission as a dietician in the MSC.

As can be seen in Table B-12, the Captain and Commander situation is unsatisfactory. Especially if one considers the recent changes in the billet structures

TABLE B-12

MEDICAL SERVICE CORPS - PROBLEM AREAS

MANNING IMBALANCE

<u>Grade</u>	<u>Authorized Billets*</u>	<u>Number On Board**</u>	<u>Percentage Manned</u>
CAPT (06)	84	42	50%
CDR (05)	205	123	60%
LCDR (04)	375	401	107%
LT (03)	695	658	95%
LTJG (02)	356	402	113%
ENS (01)	<u>109</u>	<u>95</u>	<u>87%</u>
TOTAL	1,824	1,721	94%

* Billet breakdown from BUPERS MAPMIS run dated 5 August 1975.

** Personnel count as of 1 September 1975.

that offer MSC officers greater positions of responsibility - Command of Naval Hospitals, etc. Unfortunately, the projection over the next few years is pessimistic. It can be projected that at the end of FY-77 39 Captains will be on-board. There is no remedy currently available for this problem. The passage of the DOPMA legislation appears to be the only solution on the horizon. It should be pointed out that the 94% manning (overall) is misleading since the 1,824 billets include 73 transient, patient, and prisoner billets which are not operational by nature and to which recruitment is not made. Therefore the real manning level is 98%. This problem is not numbers oriented.

The Medical Service Corps is the only Corps community within the Navy complex without Flag leadership. There is flag rank opportunity in counterpart positions within the Army, Air Force, and Public Health Service. More important than inter-service equality are such important considerations as: career progression opportunity, professional recognition, and retention considerations. The inequities of this situation are obvious. Past efforts to correct this through legislation appears to have the best chance for success. Fully supported by SECNAV and DOD, the item is #94-19 and has been referred to the House Armed Services Committee. (See Table B-13.)

TABLE B-13

MEDICAL SERVICE CORPS - PROBLEM AREAS

LACK OF FLAG LEADERSHIP

PRESENT RATIO OF FLAG RANK TO STRENGTH

<u>Promotion Category</u>	<u>Number Category</u>	<u>Flag Rank Officers</u>	<u>Ratio of Strength</u>
Line	44,408	235	1 to 189
CEC	1,364	5	1 to 273
SC	4,168	18	1 to 232
MC	3,708	16	1 to 232
JAGC	724	2	1 to 362
DC	1,730	4	1 to 432
MSC	1,733*	0	--
NC	2,626	1	1 to 2,626

* Strength as of 1/1/75; FY-76 authorized end strength of 1,805.

(Note: Above data compiled from NAVPERS 15018 of 31 Dec 1974)

F. Nurse Corps

The current billet body match in the Nurse Corps indicates full manning (99%); however the pay grade distribution is misaligned. Ensign resources are double requirements while 01-03 resources are 79% compared to 66% requirements (see Table B-14). Resolution of this problem will be slow in occurring but should be realized as the current junior officer resources flow into the career force.

The Corps has 381 male nurses and 733 married female nurses. Problems are involved in these two numbers. Male nurses have an increasing tendency to avoid direct patient care as undesirable and to show preference for administrative positions. Married female nurses view their own assignment as subordinate to their husband's assignment and feel it necessary to be stationed where their husbands are.

This assignment preference causes differential treatment problems between married and unmarried nurses. An additional related problem is that of married female reserve nurses who have small children at call-up time. Because their assignment area is severely restricted, the same type preferential treatment problems will arise in a contingency.

Procurement is entirely handled as direct appointments through the Recruiting Command to which 21 nurses are assigned for recruiting duties. Accession

TABLE B-14

NAVY NURSE CORPS BACKGROUND STATISTICS

<u>Rank</u>	<u>Authorized Billets</u>	<u>On Board</u>
Ens	276	561
LtJg	699	850
Lt	724	584
LCDR	655	338
CDR	175	164
CAPT	26	37
RADM	1	1
	<u>2,556</u>	<u>2,535</u>

USN - 896

USNR - 1,640

<u>Specialists</u>	<u>Designated Billets</u>	<u>On Board</u>
Family Nurse Practitioner	27 + 10 Students	26 + 9 Students
Pediatric Nurse Practitioner	26	17 + 4 Students
OB/GYN Nurse Practitioner	25 + 6 Students	14 + 6 Students
Midwives	2	3
Nurse Anesthetists	65	76

<u>Educational Level</u>	<u>Required</u>	<u>On Board</u>
Masters	Approx. 300	164
Bachelors	Approx. 2200	1485
Ph.D.	Not clearly defined as yet	1 + 1 Student

Presently Proposed Reductions - 1 September 1975

FY 76 - 2555
 FY 77 - 2530
 FY 78 - 2525
 FY 79 - 2520

Number of male nurses - 381 or 14% of Corps
 Number of married females - 733 or 34% of all women

quotas are determined from a comparison of requirements and potential losses.

Accessions are guaranteed 1 of 3 choices for first assignment. This restriction is a trade off for quality that can tax the system but does not cause unacceptable problems. Retention is presently very good.

G. Hospital Corps

The number of Hospital Corps billets and bodies has declined approximately 27% from 1969 to present.

	<u>Billets</u>	<u>Bodies</u>
1969	33,357	32,492
1975	24,504	23,618

Half of these reductions can be attributed to direct support of Southeast Asia commitments and the remainder to POM losses subsequent to Vietnam.

The HM operational billets are manned at or near 100%. The female enlisted figure is very close to the BUPERS/BUMED agreed limit of 3,200. Without this limit anticipated problems would be created in the sea-shore rotation for hospital corpsman.

Although the present strength of the Hospital Corps is 98.7%, an undesirable mix of technicians and general duty corpsman does present a problem. Highly trained technicians are required to support the complexities of a sophisticated health care system. In this respect specialization in the Hospital Corps is as much a problem as it is in the Medical Corps. BUMED is presently working on staffing criteria that

will balance this disparity and contribute to the total mission; operational and support.

Procurement of HM's is accomplished through normal recruiting procedures of the Navy. All permanent personnel assignments are controlled by CHNAVPERS. TAD assignments for contingencies are under the purview of the CHBUMED. BUMED's input relative to assignments may be in the form of endorsement as a major claimant or professional advisor, however, CHBUMED has no direct authority or responsibility for assignment, per se. As the Enlisted Rating Coordinator (ERC), BUMED can effect assignment policies through recommendation for detailing by NEC quota control over school input, and selection for training.

A recent opinion by JAG, prompted by the IG inspection of BUMED, removed the problem of interpretation of a statutory limit on the number of USN hospital corpsmen to which the Navy is entitled. In brief, Title 10, Sec 5401 and 5402 authorized the Navy and Marine Corps to have approximately 900,000 USN/USMC enlisted personnel and Title 10, 5412 authorized the hospital corps community to have 3.5% of the authorized figure, or 31,500. Prior to that JAG opinion, the law was interpreted by some to mean 3.5% of each year's end strength as set by Congress.

III. Problems (addressed in discussion)

A. Gapped Medical Corps billets in Fleet with over-manning at BUMED controlled activities.

B. Billet/body mismatches.

C. Excessive use of 99990 BSC in Medical Corps detailing.

D. Medical/Dental Corps promotion process, while not within the latitude of Navy control, has a major impact on the control grade ceilings when imposed for all the Navy and thus upon the other Navy officer communities.

E. Medical/Dental Corps control grade "creep."

F. Shift in the fiscal year will have a major impact on the Medical Corps planning process and will tend to decrease the MYA.

G. Officer planning data has lacked timely update.

H. Approved Medical Corps strength plans have not been utilized as control documents during fiscal year execution.

I. Medical Service Corps manpower manning imbalance.

J. The Medical Service Corps lack of Flag leadership.

K. Increasing demand on the Nurse Corps for nursing services with decreasing authorized billets.

L. Male nurse population reluctance to remain in direct patient care.

M. Married female nurses (active and reserve) that demand preferential assignment.

N. Determining valid staffing criteria for Hospital Corps to support request for additional assets.

O. Closely aligned with para. N. (above) is the need to increase billets and trained bodies for contingency demands.

P. Training billets are not available to support normal training requirements at Field Medical Service Schools for Hospital Corpsmen.

Q. Personnel shortages in operational related specialty areas such as HM-8402, nuclear submarines medical technician, HM-8492, special operations technician, and HM-8493, medical deep sea diving technician.

R. Upgrading of Independent Duty Hospital Corpsmen relative to clinical and shipboard management skills.

IV. Initiatives.

A. Problems A and B are being addressed through a concerted "no billet - no body" assignment policy. Severely restricting the use of the 99990 BSC is resolving problem C while providing the necessary control for the solution to problems A and B.

B. Negotiations are currently underway for the orderly shift of all assignment functions to BUPERS vice nominations from BUMED. It is anticipated that the detailing and placement functions currently in BUMED will be transferred to BUPERS.

C. There is significant evidence indicating that during recent months the planners in BUMED, in cooperation with BUPERS counterparts, have made a major reorientation

in their planning emphasis. This includes a definite recognition of the importance of accurate and timely strength planning as well as the use of the approved plan as a control document. This effort addresses problems G and H. The execution of Fiscal Year 76 will indicate the degree of success.

D. Within the Dental Corps, a comprehensive billet review has been completed and is under review with the intent that recommended billet changes will be initiated this fiscal year. POM requests have been made to provide increased DT billets to improve effectiveness of dental officers; however, requests in the last 2 POM submits have not been granted.

E. The Nurse Corps is presently involved in a billet validation study which will determine specific requirements for specialties and education levels.

F. In response to Problem N, the following efforts of resolution are being made.

Shore Required Operational Capabilities Statement (SHOROCS) and Shore Requirements and Manpower Planning System (SHORSTAMPS) will be the prime vehicle for developing criteria and standards. This approach is not expected to be operational for three to four years. BUMED is now attempting to develop standards through use of workload and population criteria using its own resources (workload comparison, population comparison, comparative staff analysis).

Additional billets to support both contingency and normal missions can only be acquired through either POM processes or direct reprogramming at the direction of OPNAV. Requests for additional assets will be in the form of "program" requirements with amplifying justification in POM-78 and requests through the normal manpower chain for urgent needs.

G. Initiatives being explored within BUMED to correct problem O. are enumerated below:

1. Train assets at field medical service schools directly from Hospital Corps School and "bank" in field commands.

2. Train assets at Hospital Corps School as part of curriculum.

(NOTE: Combined BUMED/CMC/BUPERS Committee will explore above possibilities.)

H. Initiatives concerning resolution of Problem Q. follows:

1. BUMED will explore the possibility of providing training and NEC assignment at E-3/E-4 level providing a larger base to expand the submarine community. This will provide additional personnel for assignment in independent HM-8402 billets as the personnel reach the E-6/E-7 level.

2. Expanded in-house recruiting, improved selection procedures and incentives such as choice shore duty, etc., for sea and diving corpsmen will help expand the operational related communities.

3. Workshop convened on 8-9 October 1975 to pursue these solutions. Attendees included personnel from Diving School, Naval Undersea Medical Institute, HSETC, Special Operations Training Command, SUBLANT, BUPERS and BUMED.

I. Provisions for upgrading of Independent Duty Corpsmen (Problem R) are outlined here:

1. Curriculum for HM-8424/25 is under revision. Emphasis will be placed on duties as shipboard medical department representatives rather than medical administration. Full time Medical Officers will be on the staff of MST schools.

2. Assignments ashore will be planned for purposes of maintaining skills.

3. Intercession with CINC's to provide additional billets for type commander staffs to insure appropriate medical supervision of ID corpsmen.

4. Incentives such as shorter sea tours, department head status on board ship, identification badge, etc., will be investigated.

V. Conclusions

A. The control grade "creep" (problem E), resulting from nearly 100% promotion opportunity to the senior grades, is recognized as a problem that we must live with in our present environment. It is also a problem that demands extremely close monitoring in the planning process. The data to accurately project promotions several years in advance is available and should be used to insure that no surprises take place during execution. The promotion of new accessions can also be reliably projected in order to plan control grade strength.

B. The major issues in the assignment area are currently recognized and understood by both BUPERS and BUMED.

C. SHOROCS and SHORSTAMPS will be the prime vehicle for developing Hospital Corps staffing criteria and standards.

D. Current initiatives have the potential for reconciling the management problems that now exist.

VI. Recommendations

A. Develop, from existing data, an accurate short range (24 months) Medical/Dental Corps promotion projection capability.

B. Count officer procurements against grade quotas for the highest grade they will hold during the fiscal year procured or the six months following procurement, whichever is longer.

C. Establish increased Hospital Corps training for contingency demands.

D. Sustain the foregoing initiatives for further improvement in the management of the Medical Department's resources. The Navy can no longer afford the luxury of casual planning in any area. It is imperative that capabilities be developed and utilized by designator advisors and BUPERS to accurately track potential accessions, generate updated loss rate data, project promotions, match billets and bodies in an assignment projection system and maintain a real time "howgozit" against the current plan. Execution variances should remain within a window of $\pm 1\%$ for a single community plan in order to maintain the overall Navy plan within a workable window.

Note: These recommendations have been incorporated into NHCRC Objective Statement #3 (Figure B-8).

Figure B-8

HEALTH CARE OBJECTIVE STATEMENT

3. MANPOWER AND PERSONNEL MANAGEMENT

AREAS OF CONCERN:

"THE SURGEON GENERAL, THE CHIEF, BUREAU OF NAVAL PERSONNEL, AND THE DEPUTY CHIEF OF NAVAL OPERATIONS (MANPOWER) (OP-01) ISSUE A JOINT FORMAL GUIDANCE PLAN ON THE MANAGEMENT OF 'HEALTH CARE MANPOWER AND PERSONNEL' INCLUDING PROCEDURES THAT MEASURE MANPOWER AND PERSONNEL UTILIZATION USING SELECTED KEY MONITORING FACTORS."

1. STRENGTH PLANNING MANAGEMENT
2. MANPOWER REQUIREMENTS PLANNING MANAGEMENT
3. PLACEMENT/DETAILING MANAGEMENT

SECTION C

NHCRC REVIEW OF NAVY MEDICAL DEPARTMENT FIXED FACILITIES

I. Purpose

To provide selected data on fixed medical department (health care) facilities, to include both BUMED Commanded and non-BUMED Commanded. The selected data includes:

Beds

Area

Plant/Equipment Valuation

Also included is a discussion of a newly issued Department of Defense Instruction (DOD INST 6015.1 as of 13 June 1975) and its effects upon the aforementioned data. The new DOD INST is entitled, "Classification, Nomenclature and Definitions Pertaining to Fixed Medical Treatment Facilities."

II. Findings

The coordination, integration, and utilization of fixed medical treatment facilities are vital to planning for a maximally effective and efficient health care system.

A. Appendix J provides (as of 1 June 1975) detailed data for individual Navy Regional Medical Centers and Navy Hospital Facilities in terms of:

UIC

Name of Facility

Normal Bed Capacity

Expanded Bed Capacity

Authorized Operating Beds

NAVFAC Listed Beds

Area Sq. Ft.

The number of authorized operating beds is determined by converting the projected average daily patient load (ADPL) to beds as 80% for 90 ADPL or more and 75% for less than 90 ADPL: i.e., 125% and 133% respectively of occupied beds, assuming sufficient personnel manning. The NAVFAC number of beds was established at the time the facility was designed, based on estimated usage in the programmed year that the facility became operational.

B. Appendix J provides (as of 1 June 1975) data for individual BUMED commanded dispensaries and branch dispensaries and for non-BUMED commanded treatment facilities in terms of:

Activity or Dispensary Location

Normal Bed Capacity

Expanded Bed Capacity

Authorized Operating Beds

C. Appendix J provides data for BUMED investment in Medical Centers and Hospitals (as of 30 June 1974) in terms of:

Facility

Land Acquisition Cost

Building & Improvements

Equipment

D. Definitions

The categories used in the appendices have been defined in the Manual of the Medical Department. These definitions are based upon Department of Defense guidance in the form of:

DODINST 6015.8 of 15 July 1955

DODINST 6015.1 of 25 September 1958

Effective 13 June 1975, these two DOD Instructions were cancelled by the issuance of DOD INST 6015.1. This latter instruction consolidated the two old Instructions with the new document to establish officially within DOD, for use by all services, uniform nomenclature and definitions applicable to:

- Classification of fixed medical treatment facilities.
- Standard nomenclature and definitions to be used in fixed medical treatment facilities in accounting for:
 - Bed capacity
 - Bed status
 - Bed occupancy
 - Patient accountability

The newly issued DODINST 6015.1 should serve to clarify some prior misinterpretations and misapplications of the earlier definitions. For purposes of comparison, Appendix J provides the old and the new definitions.

BUMED and NAVFAC are now converting their procedures for data compilations in accordance with the new DOD instruction.

APPENDIX J

Table of Regional Medical Center and Hospital
Facility Information (as of 1 June 1975)

BUMED and Non-BUMED Commanded Dispensary Bed
Capacities (as of 1 June 1975)

BUMED Investment Costs in Medical Centers and
Hospitals (as of 30 June 1974)

Comparison of Nomenclature and Definitions
Applicable Old and New DOD Instructions

SECTION D

NHCRC REVIEW OF NAVY HEALTH CARE FACILITIES MODERNIZATION PROGRAM

I. Purpose

To review the Fiscal Year 1977 through 1981 projects which have been designed to continue the Navy Medical Department's goal of upgrading or replacing inadequate health care facilities in order to provide hospitals, clinics, dispensaries, and support facilities that meet recognized standards and codes of the medical, dental, and engineering communities.

II. Discussion

On 19 February 1972, the Secretary of Defense directed the Navy to submit plans for modernizing or replacing all inadequate medical facilities during the period FY-74 to FY-78. This action effectively compressed a long-range (10- to 15-year) modernization program into five years. This compressed schedule was subsequently extended through FY 1981 since funding and implementing difficulties were encountered. Improvements in Navy health care facilities are required so that the highest attainable level of health care can be provided.

On 7 July 1975, the Assistant Secretary of Defense for Health and Environment responded to the Navy's proposed FY 77 through FY 81 health facilities modernization program by establishing a tentative funding target at

the 80 percent level of total requirements. Monies for accomplishment of the approved projects will be available from the OSD Contingency Fund.

III. Conclusions

Of the total normal bed capacity of nearly 13,000 in Navy hospitals and medical centers at the beginning of the accelerated MILCON program, approximately 40% of these beds were in temporary buildings or old buildings, constructed prior to and during World War II. Because of their age, structural unsoundness, and unreliable utility systems, these buildings were fire and safety hazards to the patients and staff who occupied them. The unreliable utility systems could not safely accommodate the increased utility needs of a modern, well-equipped hospital. The majority of these facilities did not meet the applicable safety criteria of the National Fire Protection Association (NFPA) or the accreditation requirements of the Joint Commission on Accreditation of Hospitals (JCAH).

Since the majority of the older (pre-1940) permanent hospitals were constructed primarily as inpatient care facilities, modifications to these structures became necessary to meet the increasing emphasis to serve the demand for outpatient care brought about by the recent advances in medicine. The original design of the older buildings precluded the efficient handling of large outpatient loads. The poor functional relationships among

the existing hospital ancillary services prolonged the handling of patients and seriously hampered the full utilization of the professional staff.

Barring reductions in requested funds, all major hospital facilities of temporary construction will be replaced by FY 81. The replacement/modernization program will cost:

FY 67-73	\$125,278,000
FY 74-81	<u>\$1,017,641,000</u>
TOTAL	\$1,142,919,000

Appendix K contains a detailed listing of the proposed modernization program by activity.

APPENDIX K

Summary of all Medical Military Construction (MILCON)
Program Projects by Fiscal Years 1974-1981. (Data
provided by Code 4 BUMED.)

SECTION VII

NHCRC Review of Navy Health Care
Program Planning

NHCRC REVIEW OF NAVY HEALTH CARE PROGRAM PLANNING

I. Introduction

A. This Section addresses and describes Navy health care program planning in the FYDP, CPAM and POM processes, the contents of the "Navy Medical Support Program," program sponsorship and the BUMED role with regard thereto. It also provides a discussion of the efficacy of the health care programming budgeting function in the Navy as experienced in the FY 77 cycle and projected for CPAM/POM 78. Problems and current initiatives are identified followed by conclusions and recommendations for improvements.

B. The NHCRC approach to the review of Navy health care programming and budgeting included:

1. Briefings by OP-901, OP-04, OP-01 and BUMED-02.
2. Extraction and review of CPAM/POM 77 medical support program data.
3. Interview and discussions with personnel of BUMED, OP-04, OP-09H and OP-96.

II. Discussion

A. The Navy Medical Support Program is displayed in terms of workload, manpower (officers, enlisted and civilian) and dollars (MPN, O&MN, MCON, RPN, OPN and RDT&EN appropriations) in the various resource programming documents:

FYDP - Five Year Defense Plan

CPAM - CNO Program Analysis Memoranda

POM - Program Objectives Memoranda

RAD - Resource Allocation Display (Navy
internal)

The Navy medical support program for FY 77 as contained in the Oct 75 FYDP update is shown in Appendix L. Review indicates that the bulk of resource requirements reflected therein are contained in program elements of FYDP program VIII. These program elements contain data concerning BUMED commanded and managed medical and dental activities. Significantly, Appendix L does not display medical requirements for FYDP programs I, II, III, IV, VII or IX. Yet, it is known that Navy Medical Department activities pervade all aspects of the Naval establishment and thus generate resource requirements in virtually all of the FYDP major programs. To the extent that such resource requirements are unidentified, the "Navy

Medical Support Program" is understated. What is the magnitude of the understatement? Recent studies of the Navy Health Care System (references (a) and (b)) have estimated that annual Navy medical costs approximate \$1.0 billion; the Oct 75 RAD display indicates a total program cost of \$725.1 million. Thus, the potential understatement of the Navy medical support program approximates \$250 million per year or 25% of the estimated total program cost. But equally important is the realization that these unidentified resources are not subjected to medical managerial scrutiny and review, nor integration into a total Navy health care support resource program. Thus Navy resource decisions are only directed toward the identified portions of the medical support program (the BUMED-managed program elements). This is not a new problem; it has been tacitly accepted since the early days of the FYDP process in the mid 1960's.

Ongoing total resource programming for the total Navy Medical Support Program would be difficult to maintain due to the multiplicity of program elements among which health care resources are distributed and the number of mission and resource sponsors whose programs would be effected. However, in an era of stringent resource constraints, the Navy can ill

afford to allow any program to continually remain only 75% identified in the resource programming process. The last attempt to review the total Navy medical and dental program was the OSD initiated Comprehensive Medical Services Program Review in FY-65.

B. Programming sponsorship responsibilities for the Navy Medical Support Program are divided among:

1. OP-04: Medical, and dental MILCON equipment and operations.
2. OP-01: Manpower.
3. OP-099: Medical Department Education and Training.
4. OP-098: Medical, and Dental Research.

The interrelationships among the various "sponsors" of the Navy medical support program are depicted in Figure VII-1 and defined in Appendix L.

Historically, the Navy Medical Support Program has been viewed from a mission sponsor point of view as a logistics function; thus, the primary mission sponsor assignment has been to the DCNO for Logistics, OP-04. However, in recent years, the emergence of the CPAM process within Navy has found the Medical Support Program lodged in the Manpower and Training

NAVY MEDICAL SUPPORT PROGRAM
MAJOR SPONSOR INTERRELATIONSHIPS

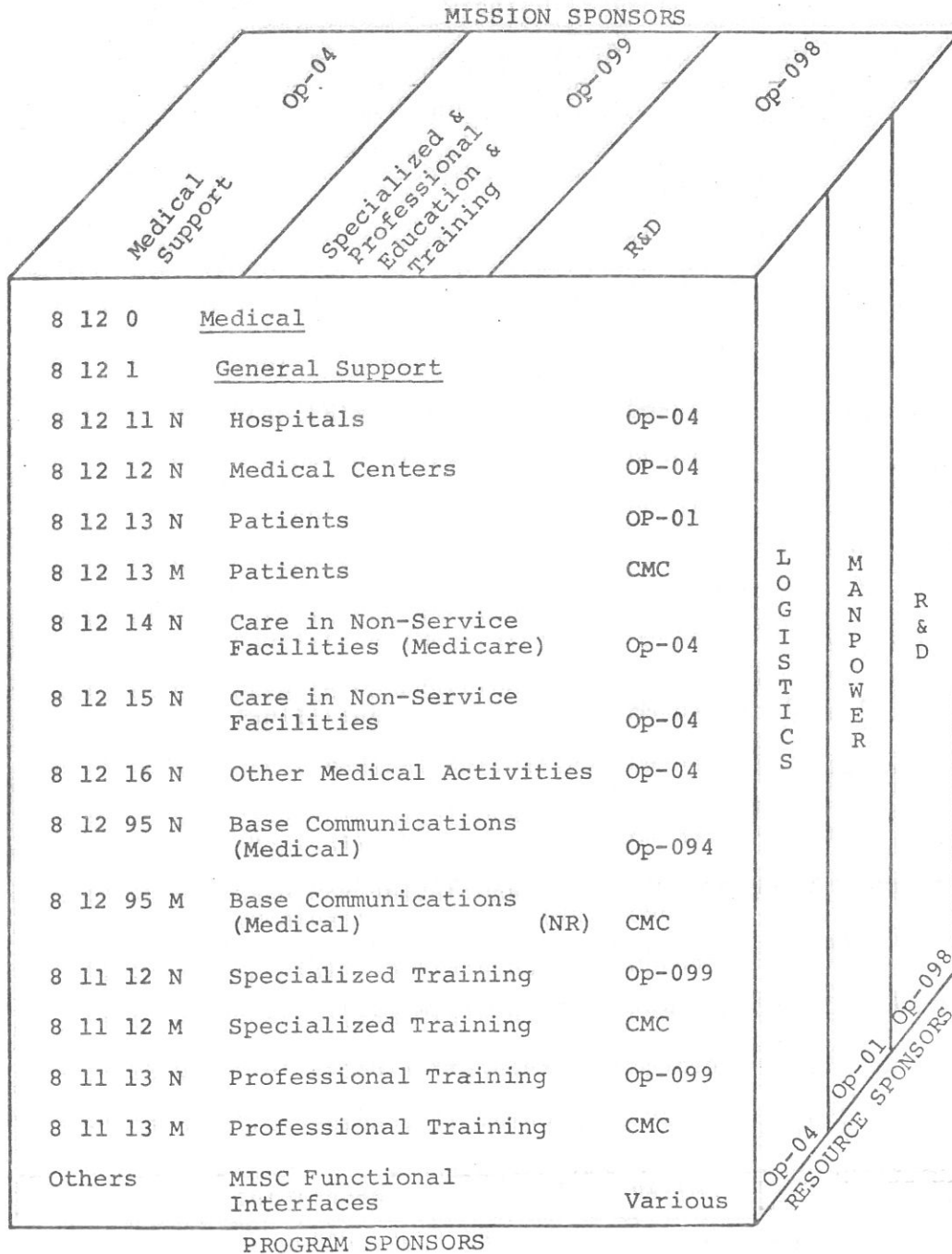


FIGURE VII-1

CPAM rather than the OP-04 directed General Logistics and Support CPAM. Further, OSD POM guidance addresses medical support in the manpower section of the POM. Such placement acknowledges the labor intensive nature of medical support but, in so doing, fails to recognize the totality of the medical and dental support effort to the Navy and Marine Corps. The end result of the CPAM/POM review placement for the Medical Support Program has diluted the effectiveness of the historical Navy sponsorship arrangements.

As discussed in Section VI the Navy Health Care System is a complex effort which interrelates all elements of clinical practice, medical and dental education and training, and R&D into a health care delivery system for the Navy and Marine Corps. The present sponsorship arrangements have led to independent, uncoordinated resource decisions which can have a counter-productive impact upon the overall medical support program.

However, the Navy looks to CHBUMED to manage the medical support program and to serve as the definitive source of information regarding Navy Health Care. Each of the sponsors draw upon BUMED as the source of information for CPAM/POM review. Thus,

separate BUMED inputs to OP-01, OP-04, OP-099, and OP-098 form the basis for CPAM/POM resource decisions.

C. The BUMED role in Navy program planning is undefined in program planning guidance. Yet, given the fragmentation of program and mission sponsorships for the Navy Health Care Program, BUMED must attempt to play the role of overall program coordination. Thus, CHBUMED must "play the CPAM/POM game" without formal recognition as a "player." Nevertheless, it is clear that the BUMED input to the respective sponsors must be well coordinated if resultant resource decisions are to have a foreseeable effect on the overall Navy Health Care Support Program. In the past this has not always been so for several reasons.

1. The several CPAM/POM inputs to the various sponsors were not coordinated through a single office within BUMED.

2. The various input documents were submitted in response to imposed deadlines distributed over a span of several months; thus, the input data was not time coordinated.

3. BUMED personnel involved in CPAM/POM submissions were concurrently engaged in OSD/OMB budget actions and congressional budget hearings.

4. Communication of CPAM/POM guidance to and within BUMED was inconsistent due to the undefined BUMED role in the program planning process.

The recent (July 1975) BUMED reorganization created an office of Program Planning and Analysis in an effort to resolve the problems encountered in the FY 76-77 CPAM/POM cycles. This office consists of three divisions: Program Planning, Management Information, and Systems Engineering. Significantly, this office is tasked to coordinate all BUMED program planning efforts commencing with the FY 78 CPAM/POM cycle. It is anticipated that this reorganization will result in substantially improved BUMED FY 78 CPAM/POM participation and, concurrent with full staffing of the office, become optimally effective for the FY 79 cycle.

D. Restructure of FYDP Program VIII was directed by DOD program change decision in September 1975 (Appendix L). The restructuring action affects a realignment of medical resources and facilities within various program elements in FYDP Program 8. Most significantly the restructuring action includes within Program 8 all medical and dental units other than tactical units. Thus, the Navy Medical Support Program must be expanded to include medical units now lodged in numerous other

program elements. Discrete resource data regarding these units are not now available in the Navy programming system. Realignment of the Navy Medical Support System to conform to the restructure will be difficult to achieve without a specific review of the newly included facilities.

The restructure decision also impacts upon the present array of medical and dental specialized and professional training. New program elements are created to provide additional visibility to health care training programs.

The intent and result of the restructure effort is to provide increased visibility on both single service and tri-service level to health care support functions and related resources. This increased emphasis reflects the increased interest directed to military health care by the administration, the several committees of Congress, and the public at large.

III. Problems

A. General interest in military health care on the part of OMB, OSD, and the Congress, has generated increasing requirements for health care support resource data. The Navy CPAM/POM process is not

appropriately configured to respond to the inordinate degree of interest in the functional, pervasive general support area of Health Care Support.

B. The Navy Medical Support Program included in CPAM/POM reviews is incomplete and does not in fact represent the total Navy Health Care Program.

Significantly, the primary mission of the Navy Medical Department, Health Care support for the operating forces of the Navy and Marine Corps, has incomplete visibility in the CPAM/POM resource allocation process. The FY 77 resource displays only include approximately 75% of the Navy's health care resources.

C. Programming sponsorship arrangements fragment the functional health care program segments under three major sponsors (and several other sponsors of minor amounts of resources).

D. The BUMED role in the program planning process is not clearly defined leading to less than satisfactory BUMED participation in the CPAM/POM process.

E. CPAM/POM cycle communications between sponsors and BUMED are less than optimal in view of the stringency of assigned deadlines and the multiplicity of BUMED and sponsor actions required.

F. FYDP Program 8 restructure requires a reevaluation of the program array which reflects Navy health care resources in FYDP, CPAM & POM documents. Such a review, virtually impossible of achievement during time constraints of the FY 78 POM cycle, will be essential to the FY 79 POM cycle.

IV. Current Initiatives

A. BUMED creation of a separate program planning and analysis office recognizes past problems in CPAM/POM participation. Result should be increased efficacy in BUMED participation beginning with the FY 78 CPAM/POM cycle.

B. FYDP Program 8 restructure initiated by OSD will provide the documentation for a more complete CPAM/POM review of Navy Health Care Program resources.

V. Recommendation

Op-090 review Navy Medical Support program planning in the following three areas:

A. Sponsorship assignments for the Navy Health Care Support Program; develop appropriate changes for implementation prior to the FY 79 CPAM/POM cycle.

C. Clear, timely communication lines to facilitate BUMED participation in FY 78 CPAM/POM processes.

C. Program 8 restructure review to ensure compliance with OSD guidance contained in DPPG and PCDs.

References:

- a. OMB/HEW/DOD Military Health Care Study
- b. Boeing Computer Services Inc. Navy Medical Care Study, 1974

SECTION VIII

Summary of Principal Findings and Conclusions

SECTION VIII

SUMMARY OF PRINCIPAL FINDINGS AND CONCLUSIONS

I. Purpose

This section provides a summary of the principal findings of the review as extracted from the many conclusions contained in the several sections of this report.

II. Findings

The principal findings are:

A. The Navy Health Care System consists of the sum total of the functions and resources of the Navy Medical Department plus the outservice patient care services procured from civilian health care services, under the CHAMPUS and active duty outservice health care programs.

B. The Navy Health Care System is subject to strong external influences, pressures and demands based upon the increasing interest in health care on the part of the Congress, Office of the Secretary of Defense and the Office of Management and Budget; this interest is coupled with a propensity to compare military health care against civilian community programs and standards.

C. These external influences affect:

1. beneficiary population categories for whom the system must provide health care services;
2. health care entitlements of the various beneficiary categories;

3. the quantity and variety of health care services to be provided, and

4. Navy resource allocations for health care.

D. The Navy Health Care System is primarily oriented to these external pressures, influences and demands.

E. The increase in external influences and pressures in a time of stringent resource constraints has resulted in a corresponding decrease in Navy Health Care System responsiveness to the needs of active duty personnel and the operating forces of the Navy and Marine Corps.

F. The Navy Health Care System is basically sound in providing patient care at least equal in quality to that obtainable in the civilian health care community.

G. There are significant differences between civilian and Navy health care requirements. The primary differences are reflected in the necessity for Navy medical department personnel to practice general Naval and Naval health care equivalent skills in addition to civilian health care equivalent skills.

H. Provision of health care services does not emphasize priority service to active duty personnel and the operating forces of the Navy and Marine Corps.

I. Current levels of contingency training of Medical Department personnel and current availability of amphibious medical support facilities are inadequate to deal with an opposed FMF landing in which significant numbers of casualties would be sustained.

J. Navy health care manpower and personnel management practices do not give appropriate emphasis to medical support for the operating forces.

K. Health Care Education and Training programs do not give appropriate emphasis to general Naval skills and Navy health care equivalent skills.

III. Conclusion

The findings summarized above have led the Committee to formulate a major conclusion that:

The Navy Health Care System needs reorientation and redirection to emphasize priority health care support to active duty personnel and the operating forces of the Navy and Marine Corps.

Further, an appropriate mechanism by which to provide the requisite redirection is through annual CNO Program Planning Guidance (CPPG) and CNO Program Fiscal Guidance (CPFG) documents as an integral part of the Navy program planning process.

SECTION IX

Compendium of Objective Statements
and Recommendations

SECTION IX

COMPENDIUM OF OBJECTIVE STATEMENTS AND RECOMMENDATIONS

The objective statements and recommendations made by the NHCRC are presented in this compendium for convenience. For a definitive explanation of these recommendations, the reader should also review:

- the related section of the report, as indicated, or
- the applicable architectural and action plan contained in Section X.

The objective statements, when approved, constitute CNO direction for the Navy Health Care System of the future. The major recommendations and other recommendations are directed toward resolution of existing problems in the present system as they impact on the Navy Health Care System for the future.

A. Navy Health Care Objective Statements

1. "SURGEON GENERAL issue policy guidance to ensure that health care support to the operating forces of the Navy and Marine Corps is the highest priority of the Navy Health Care System."

Areas of Concern:

- a. Health Care Support Priorities
- b. Responsiveness of Health Care System to the Operating Forces
- c. Health Care System Communication

2. "SURGEON GENERAL/CHIEF, BUREAU OF MEDICINE AND SURGERY establish and conduct a requirements based education and training program that develops and maintains the appropriate balance of Naval health care support personnel that are professionally proficient and clinically competent in the Naval officer and enlisted, Naval health equivalent, and civilian health equivalent skills required to support the needs of the Navy Health Care System beneficiaries."

Areas of Concern:

- a. Requirements Based E&T
- b. Naval Skills, GNT
- c. Navy Health Equivalent (NHE) Skills
- d. Civilian Health Equivalent (CHE) Skills

3. "THE SURGEON GENERAL, THE CHIEF, BUREAU OF NAVAL PERSONNEL, AND THE DEPUTY CHIEF OF NAVAL OPERATIONS (MANPOWER) (OP-01) issue a joint formal guidance plan on the management of 'Health Care Manpower and Personnel' including procedures that measure manpower and personnel utilization using selected monitoring factors."

Areas of Concern:

- a. Strength Planning Management
- b. Manpower Requirements Planning Management
- c. Placement/Detailing Management

4. "CHIEF, BUREAU OF MEDICINE AND SURGERY increase the emphasis on the preventive and environmental medicine

component of Navy health care support by developing an effective capability for the timely identification and evaluation of health risks in order to minimize the effects of health risks to Navy and Marine Corps personnel."

Areas of Concern:

- a. Identification of Health Risks to Personnel
- b. Risk Neutralization
- c. Effective Command Application

B. Major Recommendations:

1. Surgeon General initiate and maintain frequent communications with CMC in order to ensure that both the quantity and quality of medical department personnel to support FMF health care requirements, in both peace and war, be met or at least be given the same priority and consideration as Navy requirements. (Ref: Volume I, Section II, Section D)

2. CNO (OP-090) review Navy Medical Support program planning in the following three areas:

- Sponsorship assignments for the Navy Health Care Support Program; develop appropriate changes for implementation prior to the FY 79 CPAM/POM cycle.

- Clear, timely communication lines to facilitate BUMED participation in FY 78 CPAM/POM processes.

- FYDP Program 8 restructure review to ensure compliance with OSD guidance contained in DPPG and PCDs.

(Ref: Volume I, Section IV, Section A)

3. Classified recommendations are contained in Volume III which address development of an alternative for offshore medical support facilities, and modern medical advance base functional components to provide contingency medical support to an Amphibious Task Force/Landing Force. (Reference: Volume III, Section II)

C. Recommendations

1. CHBUMED formulate more explicit criteria and guidelines whereby NHCS civilian interrelationships, objectives, functions, and expected benefits are delineated and evaluated. (Reference: Volume I, Section III, Section A)

2. CHBUMED use the definitions of health care categories identified by the NHCRC to provide a commonly understood doctrinal frame of reference. (Reference: Volume I, Section V, Section B)

3. CNO/CMC designate CHBUMED as the single source of Navy and Marine Corps health care population data for use in support of any interservice/OSD sponsored Tri-Service population information collection effort. (Reference: Volume I, Section II, Section A)

4. SGN/CHBUMED adopt the NHCRC definition of "Navy Health Care Support Requirements" to the greatest extent possible as the basis upon which to evaluate and appropriately balance the orientations, skills, and capabilities of Navy Medical Department personnel. (Reference: Volume I, Section II, Section B)

5. CHBUMED develop more meaningful and effective measures of medical workload to incorporate some indication of relative intensity and/or complexity of direct patient care provided in terms of injury, illness and wound care, as well as the work performed in dealing with the remaining functions of health care support identified as preventive medicine, health care planning, and health care logistics.

6. CNO, CMC and SGN direct a conjoint in-depth staff assessment of information pertaining to:

a. the evolution of further centralized health care management and consolidation.

b. the implications for the Navy Health Care System resulting from National Health Insurance legislation.

Assessment of alternatives, decisions and positions should assure the continuance of adequate, appropriate and responsive health care support for, at least, all ACDU personnel under the conditions of the four categories of health care support requirement defined by the NHCRC.

(Reference: Volume I, Section III, Section B)

SECTION X

Architectural Health Care Plans
and Action Plans

Section A - Navy Health Care Review Committee Architectural
Plan Summary

Section B - Navy Health Care Review Committee Summary
of Major Recommendations

Section C - Navy Health Care Review Committee
Summary of Recommendations

SECTION X

ARCHITECTURAL AND ACTION PLANS

Section A of this Section has two parts for each NHCRC objective statement. The first part, the Architectural Plan, is a time phased implementation scheme of each objective statement's major areas of concern and key elements. The second part, the Action Plan, is a detailed narrative description of the key elements of the architectural plan. It includes a standard or the general resultant goal of each key element. Essentially the action plan is a detailed description of what is recommended and the architectural plan is the time phasing of when it should be accomplished. Together these plans delineate the details necessary to achieve the goals.

Sections B and C have combined the Architectural and Action plans of these recommendations into a single format. The goals and details are written into the action statements on the time phasing charts. Since these recommendations are not as complex as the objective statements, the level of detail required for implementation was limited to the simple narrative of the action steps.

NAVY HEALTH CARE REVIEW COMMITTEE ARCHITECTURAL PLAN SUMMARY

A. OBJECTIVE STATEMENTS

1. HEALTH CARE SUPPORT TO THE
OPERATING FORCES

2. MEDICAL DEPARTMENT E&T

3. MANPOWER & PERSONNEL MANAGEMENT

4. PREVENTIVE MEDICINE

FISCAL YEAR										
76	77	78	79	80	81	82				
X		X		/						
	X	X (Interim)			X					
	X			/	X					
X		X (Interim)	X							
				/						
				/						

NAVY HEALTH CARE REVIEW COMMITTEE ARCHITECTURAL PLAN
OBJECTIVE STATEMENT #1

		FISCAL YEAR											
		76	77	78	79	80	81	82					
OBJECTIVE STATEMENT: Health Care Support to the Operating Forces													
AREAS OF CONCERN:													
a.	Health Care Support Priorities	X		X									
b.	Responsiveness of Health Care System to the Operating Forces	X		X									
c.	Health Care System Communication	X		X									

/
 /
 /
 /

HEALTH CARE SUPPORT TO THE OPERATING FORCES, AREAS OF CONCERN
OBJECTIVE STATEMENT #1

AREA OF CONCERN	FISCAL YEAR									
	76	77	78	79	80	81	82			
a. HCS Priorities										
(1) Health Care Policies										
(a) CHBUMED propose policies		X								
(b) OPNAV review policies			X							
(c) CHBUMED promulgate policies FY 77			X							
(d) FLTCINCs review outcomes annually										
(2) HCS Logistics, Equipment Readiness										
(a) SGN/FLT MED officers develop repair standards		X								
(b) CHBUMED publish repair priority		X								
(c) FLTCINCs monitor medical readiness reports										
Ongoing										

HEALTH CARE SUPPORT TO THE OPERATING FORCES, AREAS OF CONCERN
OBJECTIVE STATEMENT #1

AREA OF CONCERN	FISCAL YEAR											
	76	7T	77	78	79	80	81	82				
b. Responsiveness of HCS to Operating Forces												
(1) HCS Services Management												
(a) BUMED/FLT medical offices develop standards of service guidelines		X										
(b) BUMED publish compliance requirements			X									
(c) BUMED/Flt medical offices provide effectiveness reports annually												
(d) OPNAV monitor Step (c)				X								
(e) CHBUMED/FLTCINCs identify resource increments for POM development				X								
(2) HCS Accountability												
(a) FLTCINC/CNP identify ASOC*		X										
(b) CNP issue ADDU orders assigning NRMC/NRDC COs to ASOC			X									
(c) FLTCINCs issue process guidance			X									
(d) FLTCINCs monitor accountability effectiveness annually				X								

* Area Senior Operational Commanders

HEALTH CARE SUPPORT TO THE OPERATING FORCES, AREAS OF CONCERN
OBJECTIVE STATEMENT #1

AREA OF CONCERN	FISCAL YEAR						
	76	77	78	79	80	81	82
c. Health Care System Communication							
(1) SGN/FLTCINCs develop proposed SECNAVINST		X			/		
(2) FLTCINCs implement Council meetings		X					
(3) FLTCINCs/CNP review Council effectiveness annually			X		/		
(4) INSGEN inspections/Operational Readiness inspections assess Council effectiveness			X		/		
					/		

HEALTH CARE SUPPORT TO THE OPERATING FORCES:
CNO OBJECTIVE STATEMENT, AREAS OF CONCERN,
STANDARDS, AND ACTION PLANS

1. "Surgeon General issue policy guidance to ensure that health care support to the operating forces of the Navy and Marine Corps is the highest priority of the Navy Health Care System."

a. AREA OF CONCERN - HEALTH CARE SUPPORT PRIORITIES

(1) Health Care Policies

STANDARD

Navy Health Care System policies established
by the Surgeon General that:

- Ensure the earliest return of active duty personnel to a duty status when physically and functionally fit for the assigned duty
- Meet the medical and dental needs of active duty personnel within Naval and civilian professional standards

ACTION PLAN

- (a) SGN/CHBUMED develop by 7/1/76 proposed policies to meet the standard.
- (b) OPNAV approve the proposed policies by 10/1/76.
- (c) SGN/CHBUMED promulgate the policies by 11/1/76 and review their effectiveness annually.
- (d) FLTCINCS review (initially 7/1/77) general effectiveness of the policies annually;

submit suggested corrections to SGN
and OPNAV.

(2) Health Care Logistics

STANDARD

FLT medical/dental equipment maintained in
Readiness Condition C-1.

ACTION PLAN

- (a) SGN/FLT Medical Officers assess medical/
dental equipment repair capabilities by
7/1/76.
- (b) SGN/CHBUMED establish policy by 8/1/76 which
directs optimal use of medical and dental
equipment repair capabilities with the
highest priority given to the maintenance
of the operational forces medical and dental
equipment.
- (c) FLTCINCs assess effectiveness equipment
repair by review of medical material read-
iness reports; unsatisfactory reports
directed to CHBUMED for immediate action.

b. AREA OF CONCERN - RESPONSIVENESS OF HEALTH CARE
SYSTEM TO OPERATING FORCES

(1) Management of health care support services:

STANDARD

Clinical services guidelines for support of
operating forces personnel which include:

- Access time parameters
- Priorities for arriving or deploying units
- Identification of optimal scheduling of personnel of operating forces for inpatient and outpatient services
- Identification of inpatient and outpatient workload data for clinical procedures and services provided to the operating force personnel as subset of active duty personnel
- Assurances that clinical referrals and consults receive proper priority at professional levels
- Provision of consistent point of access and point of contact to health care services at medical department facilities
- Provision of continuing communication to unit commanders concerning status and anticipated length of stay for active duty personnel.

ACTION PLAN

- (a) BUMED/FLT medical offices develop standards of service guidelines by 7/1/76.
- (b) CHBUMED issue instruction by 10/1/76 directing NRMCMC compliance with the standards.

- (c) BUMED/FLT medical offices report initially 10/1/77 and annually as to effectiveness of standards of service program.
 - (d) OPNAV review report.
 - (e) CHBUMED/FLTCINC analyze standards of service program for resource requirement shortfalls, reprogramming alternatives, and identification of new resource requirements for POM development.
- (2) Health Care System Accountability

STANDARD

NRMC/NRDC commanders accountable to designated Area Senior Operational Commanders (ASOC) for health care support provided to operating forces personnel.

ACTION PLAN

- (a) FLTCINC identify cognizant Area Senior Operational Commanders to CNP in each NRMC/NRDC by 6/1/76.
- (b) CNP issue orders assigning NRMC/NRDC commanders ADDU to designated ASOC by 7/1/76.
- (c) FLTCINC issue health care support management procedural, reporting, and complaint processing guidance effective 9/1/76.
- (d) FLTCINC monitor effectiveness of accountability standard and report annually (initial 7/1/77) to OPNAV, copy to CHBUMED.

c. AREA OF CONCERN - HEALTH CARE SYSTEM COMMUNICATION

STANDARD

Regional Health Care Advisory Councils established to function as a major instrument for communication.

- Purpose - to review, discuss and resolve health care support matters and problems
- Chairman - Area Senior Operational Commander
Members: NRMC/NRDC commanders and others as designated by ASOC
- Proceedings - meet monthly: maintain records of Council proceedings; publish and disseminate information as to actions advised and actions accomplished.

ACTION PLAN

- (1) SGN develop with FLTCINC concurrence a proposed SECNAV instruction which authorizes establishment of Regional Health Care Advisory Councils
- (2) Council Chairman convene initial applicable meeting within 30 days of the signing of the SECNAV instruction.
- (3) FLTCINCS/CNP review effectiveness of the standard annually beginning 7/1/77
- (4) INSGENINSP/ORI assess effectiveness of Council productivity.

NAVY HEALTH CARE REVIEW COMMITTEE ARCHITECTURAL PLAN
OBJECTIVE STATEMENT #2

OBJECTIVE STATEMENT: Medical Department
Education and Training (E&T)

FISCAL YEAR

AREAS OF CONCERN:

a. Requirements Based E&T Plans

b. Naval Skills, GNT (Initial and
continuing)

c. Navy Health Equivalent Skills,
Basic

d. Civilian Health Equivalent Skills
General and Specialty

	76	77	78	79	80	81	82
a. Requirements Based E&T Plans		X	(Interim)		X		
b. Naval Skills, GNT (Initial and continuing)		X		X			
c. Navy Health Equivalent Skills, Basic		X	X				
d. Civilian Health Equivalent Skills General and Specialty		X	X				

OBJECTIVE STATEMENT #2
MEDICAL DEPARTMENT EDUCATION AND TRAINING AREAS OF CONCERN

FISCAL YEAR

AREA OF CONCERN

a. REQUIREMENTS BASED E&T PLANS

(1) Overall E&T Plan

(a) CHBUMED/OP-01 proceed
with STAFTAR,
SHORSTAMPS

(b) CHBUMED issue
staffing and services
criteria

(c) SGN/FLTCINCS issue staffing and services criteria

(d) CHBUMED publish annual E&T policy document

(e) DNET review step (d) annually

(2) Iterative Corps Community Plan

(a) CHBUMED publish annual plans

(b) CHBUMED develop
analytic display
annually for CPAM

(c) DNET monitor requirements plan

I-297

OBJECTIVE STATEMENT #2
MEDICAL DEPARTMENT EDUCATION AND TRAINING AREAS OF CONCERN
FISCAL YEAR

AREA OF CONCERN

b. NAVAL SKILLS, GNT, INITIAL AND CONTINUING

(1) GNT, initial

(a) CNET review existing programs

(b) CHBUMED maintain programs

(c) DNET review program effectiveness annually

(2) GNT, continuing

(a) SGN establish program policy

(b) SGN/CHBUMED implement policy in curricula plans

(c) CHBUMED develop accounting mechanism

(d) DNET monitor accounting measures annually

(e) CHBUMED annually develop analytic display for POM development, initially by 10-1-76

	76	77	78	79	80	81	82
		X					
Ongoing							
		X					
		X					
		X					
		X					
		X					
		X					

OBJECTIVE STATEMENT #2
MEDICAL DEPARTMENT EDUCATION AND TRAINING AREAS OF CONCERN

AREA OF CONCERN	FISCAL YEAR									
	76	77	78	79	80	81	82			
c. BASIC HEALTH EQUIVALENT SKILLS (NHE)										
(1) SGN establish NHE proficiency policy		X				/				
(2) CHBUMED incorporate policy into E&T curricula plans			X							
(3) CHBUMED develop annually analytic display for POM development		X				/				
						/				
						/				

OBJECTIVE STATEMENT #2
MEDICAL DEPARTMENT EDUCATION AND TRAINING AREAS OF CONCERN
FISCAL YEAR

AREA OF CONCERN

d. CIVILIAN HEALTH EQUIVALENT SKILLS

- General and Specialty CHE Skills

(1) CHBUMED display E&T programs annually

(2) CHBUMED prioritize E&T programs annually

(3) CHBUMED develop analytic spread annually for POM development

I-300

MEDICAL DEPARTMENT EDUCATION AND TRAINING:
CNO OBJECTIVE STATEMENT, AREAS OF CONCERN,
STANDARDS AND ACTION PLANS

2. "Surgeon General/Chief, Bureau of Medicine and Surgery establish and conduct a requirements based education and training program that develops and maintains the appropriate balance of Naval health care support personnel that are professionally proficient and clinically competent in the Naval officer and enlisted, Naval health equivalent, and civilian health equivalent skills required to support the needs of the Navy Health Care System beneficiaries."

a. AREA OF CONCERN - REQUIREMENTS BASED E&T

(1) Overall Requirements Based Training Plan:

STANDARD

SGN annual policy document which reflects the scope, nature, broad objectives, emphasis, priorities, and direction of Medical Department E&T Programs.

ACTION PLAN

- (a) CHBUMED/OP-01 proceed with Medical Department portion of SHORSTAMPS, STAFFTAR, (refer to "Architectural Plan of Manpower and Personnel Management Objective Statement")
- (b) CHBUMED develop and issue staffing/services criteria: (refer to "Architectural Plan of Manpower and Personnel Management Objective Statement")

Clinics
Hospitals
Centers

- (c) SGN/FLTCINCs develop and issue staffing and services criteria for operating forces

Medical Department activities. (Refer to "Architectural Plan of Health Care Support to the Operating Forces Objective Statement")

- (d) CHBUMED publish annually beginning 1 Aug 76 the overall planning document for each E&T program for the POM Year + 4.
- (e) DNET review overall Medical Department E&T policy document for accuracy of content and consistency with current CNO objectives and report discrepancies and corrections to CHBUMED.

(2) Comprehensive Iterative Corps Community Requirements Based Training Plan.

STANDARD

SGN annual requirements based training policy document for E&T programs by corps community and by quantity and quality of skill including subspecialty designator.

ACTION PLAN

- (a) CHBUMED publish iterative plans annually beginning 8/1/76, for the POM Year +4.
- (b) CHBUMED develop from review of the training plans and personnel strength plans an analytic based display which identifies the number and percent of shortfalls in meeting requirements by NOBC/NEC,

alternatives for correction, and impacts as appropriate for the POM Year + 4.

- (c) DNET monitor iterative requirements plan as mission sponsor, (begin POM 79 development cycle.)

b. AREA OF CONCERN - NAVAL SKILLS, GNT, INITIAL AND CONTINUING

- (1) General Navy Training (GNT), initial, all Medical Department Officer Corps communities:

STANDARD

100% of Medical Department Officers receive military, Navy, and Marine Corps familiarization and orientation prior to commencing an initial tour of duty.

ACTION PLAN

- (a) CNET review the content of the initial Medical Department Officer indoctrination curricula and programs with SGN and CNP and assess this program effectiveness.
 - (b) CHBUMED develop with CNET and maintain optimal indoctrination programs.
 - (c) DNET review annually effectiveness of ongoing indoctrination programs. DNET report discrepancies to CHBUMED/CNET.
- (2) General Navy Training (GNT), continuing, all corps communities.

STANDARD

- Centrally managed formal in-service Medical Department E&T programs of six months or more duration include at least 80 hours GNT each year or portion thereof as a condition for trainees to advance or complete program.
- Centrally managed Medical Department conducted short courses, seminars, symposia dedicate a minimum of 5% of the curriculum to GNT.
- GNT course plans contain explicit learning objectives expressed in behavioralistic terms.

ACTION PLAN

- (a) SGN establish with CNET continuing GNT curriculum policy for centrally managed in-service conducted Medical Department E&T programs - formal programs and short courses by 10/77.
- (b) SGN/CHBUMED implement policy to incorporate continuing GNT curriculum plans into all programs by 1/77.
- (c) SGN/CHBUMED/CNET develop accountability mechanism to quantify Medical Department personnel participation and to analyze continuing GNT curriculum effectiveness, by 1/77.
- (d) DNET monitor accountability mechanism annually.
- (e) CHBUMED display for POM development identification of resources required to adequately

meet the standard for both initial and continuing GNT, proposed alternatives for correction of shortfalls, and impacts as appropriate for POM Year + 4.

c. AREA OF CONCERN - NAVY HEALTH CARE SUPPORT EQUIVALENT (NHE) SKILLS, ALL CORPS COMMUNITIES

STANDARD

- Centrally managed Medical Department conducted in-service E&T programs provide an effective emphasis on maintaining Medical Department personnel at appropriate and adequate levels of proficiency in basic NHE skills within all four categories of operational health care support.
- Course plans contain explicit learning objectives expressed in behavioralistic terms.

ACTION PLAN

- (1) SGN establish policy which directs the incorporation of the standard in centrally managed Medical Department conducted in-service E&T programs by 8/76.
- (2) CHBUMED incorporate policy into program curricula all of which reflect compliance with the standard by 7/77.
- (3) CHBUMED develop an analytic based display which reveals the resource reprogramming

required to meet the standard, alternatives for correction of the shortfalls, and impacts as appropriate for POM Year + 4.

d. AREA OF CONCERN - CIVILIAN HEALTH CARE SUPPORT
EQUIVALENT (CHE) SKILLS

- General and Specialty, all corps communities

STANDARD

- Centrally managed formally conducted in-service training programs meet the accepted minimum essential standards for civilian accreditation and certification.
- CHE course plans contain explicit learning objectives expressed in behavioralistic terms.

ACTION PLAN

- (1) CHBUMED develop by 10/76 a display of all centrally managed programs and the relative degree to which they are all subject to review by and application of national standards of accreditation, certification.
- (2) CHBUMED develop by 10/76 a display of all programs which require meeting of recognized civilian national standards and prioritize the displayed programs in descending orders of essentiality to the Navy.
- (3) CHBUMED display for POM-79 development identification of resources required to

conduct centrally managed E&T programs which must meet national minimum essential standards, proposed alternatives for correction of shortfalls, and impacts as appropriate for POM-79 development.

NAVY HEALTH CARE REVIEW COMMITTEE ARCHITECTURAL PLAN
OBJECTIVE STATEMENT #3

FISCAL YEAR

OBJECTIVE STATEMENT: Manpower
and Personnel Management

AREAS OF CONCERN

a. Strength Planning Management

b. Manpower Requirements
Planning Management

c. Placement/Detailing Management

	76	7T	77	78	79	80	81	82
a. Strength Planning Management		X	X			/		
b. Manpower Requirements Planning Management		X				/	X	
c. Placement/Detailing Management		X		X		/		
						/		
						/		

MANPOWER AND PERSONNEL MANAGEMENT AREAS OF CONCERN
NHCRC OBJECTIVE STATEMENT #3

AREA OF CONCERN

FISCAL YEAR

a. STRENGTH PLANNING MANAGEMENT

- (1) CHBUMED develop promotion projection
- (2) CHBUMED develop loss projection
- (3) CHBUMED develop year group planning
- (4) CHBUMED develop accession projection
- (5) CHBUMED publish (1) thru (4) in strength plans
- (6) CHBUMED develop a tracking technique and monitor plan execution

	76	77	78	79	80	81	82
			X				
(1) CHBUMED develop promotion projection	X				/		
(2) CHBUMED develop loss projection		X					
(3) CHBUMED develop year group planning			X		/		
(4) CHBUMED develop accession projection			X				
(5) CHBUMED publish (1) thru (4) in strength plans			X				
(6) CHBUMED develop a tracking technique and monitor plan execution		X			/		
					/		

MANPOWER AND PERSONNEL MANAGEMENT AREAS OF CONCERN
NHCRC OBJECTIVE STATEMENT #3

AREA OF CONCERN	FISCAL YEAR											
	76	77	78	79	80	81	82					
b. MANPOWER REQUIREMENTS PLANNING MANAGEMENT												
(1) CHBUMED/OP-01 proceeds with STAFFTAR/SHORSTAMPS		X			∫	X						
(2) CHBUMED publish annual requirements for E&T plan		X	X	X	X	X	X					
(3) CHBUMED verify STAFFTAR/SHORSTAMPS output			X		∫	X						
(4) CHBUMED/CHNAVPERs review training output			X	X		X	X					
					∫							
					∫							

MANPOWER AND PERSONNEL MANAGEMENT AREA OF CONCERN
NHCRC OBJECTIVE STATEMENT #3

AREA OF CONCERN

FISCAL YEAR

c. PLACEMENT/DETAILING MANAGEMENT

(1) CHBUMED limit use of 99990 BSC

(2) CHNAVPERS/CHBUMED realign
detailing/placement functions

(3) CHNAVPERS firm policy on use of
99990 BSC

(4) CHBUMED maintain O.F. manning
at or above 98%

(5) CHNAVPERS/CHBUMED develop
implement monitor plan

	76	77	78	79	80	81	82
				X			
	X				/		
				X			
	X				/		
		X			/		
		X			/		
					/		
					/		

MEDICAL DEPARTMENT MANPOWER AND PERSONNEL
MANAGEMENT: CNO OBJECTIVE STATEMENT, AREAS OF
CONCERN, STANDARDS AND ACTION PLANS

3. "The Surgeon General, the Chief, Bureau of Naval Personnel, and the Deputy Chief of Naval Operations (Manpower) (OP-01) issue a joint formal guidance plan on the management of 'Health Care Manpower and Personnel' including procedures that measure manpower and personnel utilization using selected monitoring factors."

a. AREA OF CONCERN - STRENGTH PLANNING MANAGEMENT

STANDARD

Published strength plans in accordance with OP-01/
CHNAVPERS/CHBUMED formal guidance.

ACTION PLAN

- (1) CHBUMED develop an interim promotion projection and planning capability by 1 June 1976 to be followed by a permanent capability when action steps (2) and (3) below are complete.
- (2) CHBUMED develop a computer based loss projection capability with sufficient quality detail to meet anticipated CHBUMED/CHNAVPERS planning needs by 1 September 1976.
- (3) CHBUMED develop by 1 March 1977 a year group structure planning capability that accounts for the experience needs of the projected billet structure, career progression needs, and anticipated loss patterns.
- (4) CHBUMED develop an accession planning and projection capability that accounts for maintenance

of year group structuring and meets the needs of education and training plans (refer to Education and Training Objective Statement) by 1 June 1977.

- (5) CHBUMED incorporate, through a central point, the synthesis of (1) through (4) above to publish strength plans that meet CHNAVPERS planning constraints that do not exceed $\pm 1\%$ deviation on a monthly basis by 1 September 1977.
- (6) CHBUMED develop a tracking technique by 1 Sept 1976 and monitor plan execution on a continuing basis to formally alert CHNAVPERS in the event a deviation occurs beyond $\pm 1\%$.

b. AREA OF CONCERN - MANPOWER REQUIREMENTS PLANNING
MANAGEMENT

STANDARD

Formal staffing criteria developed and published jointly by CNO/CHBUMED via STAFFTAR and SHORSTAMPS.

ACTION PLAN

- (1) CHBUMED/CNO (OP-01) proceed with Medical Department portion of STAFFTAR and SHORSTAMPS.
- (2) CHBUMED publish annually manpower requirements to support training plan for all Medical Department communities.
- (3) When SHORSTAMPS and STAFFTAR are fully implemented (FY 80 and 1 July 1976, respectively), CHBUMED conduct review and update and/or verification of staffing requirements annually.

- (4) CHBUMED/CHNAVPERS review, at least annually, the output of training programs in relation to published training plans (refer to Education and Training Objective Statement.)

c. AREA OF CONCERN - PLACEMENT/DETAILING MANAGEMENT
(Billet and Body Matching)

STANDARD

Adherence to CHNAVPERS/CHBUMED published policies and procedures.

ACTION PLAN

- (1) CHBUMED minimize the use of the 99990 BSC in order nominations.
- (2) CHNAVPERS and CHBUMED formalize current efforts to realign detailing and placement functions in published procedures.
- (3) CHNAVPERS maintain a firm policy on use of 99990 BSC (no billet - no body)
- (4) CHBUMED initiate and maintain operating forces Medical Department billet manning levels at no less than 98% by 1 October 1976.
- (5) CHNAVPERS monitor implementation on a regular basis. CHNAVPERS develop a plan with CHBUMED by which to achieve implementation monitoring by 1 Oct 1976.

NAVY HEALTH CARE REVIEW COMMITTEE ARCHITECTURAL PLAN
OBJECTIVE STATEMENT #4

OBJECTIVE STATEMENT: Preventive Medicine

AREAS OF CONCERN:

FISCAL YEAR

- a. Identification of Health Risks to Personnel
- b. Risk Neutralization
- c. Effective Command Application

	76	77	78	79	80	81	82
a. Identification of Health Risks to Personnel	X		X (Interim)	X	/		
b. Risk Neutralization	X		X		/		
c. Effective Command Application			X	X	/		

OBJECTIVE STATEMENT #4
PREVENTIVE MEDICINE AREAS OF CONCERN

AREA OF CONCERN	FISCAL YEAR											
	76	77	78	79	80	81	82					
a. IDENTIFICATION OF HEALTH RISKS TO PERSONNEL	X		X (Interim)	X	/							
(1) Epidemiology Health Risks												
(a) BUMED develop a formalized system for a world-wide disease/injury incidence profile	X		X		/							
(b) BUMED maintain profile current, quarterly verification			X									
(2) Environmental Health Risks					/							
(a) BUMED identify and collect the established Navy and civilian environmental standards of health	X	X			/							
(b) BUMED publish the standards		X			/							
(c) BUMED maintain the publication current (annual verification)			X	X	X	X	X					

OBJECTIVE STATEMENT #4
PREVENTIVE MEDICINE AREAS OF CONCERN

AREA OF CONCERN

FISCAL YEAR

a. (Cont.) IDENTIFICATION OF HEALTH RISKS TO PERSONNEL

(3) Occupational Health Risks

(a) BUMED identify and collect the established Navy and civilian occupational (industrial/commercial) standards of health

(b) BUMED publish the standards

(c) BUMED maintain the publication current (annual verification)

(4) Operational Health Risks

(a) BUMED collect from the various sources of doctrine publications the applicable operational (air, surface, subsurface, and land) health hazards

(b) BUMED publish a single hazard compendium

(c) BUMED validate the compendium annually

(d) BUMED evaluate the programmed geographic operational (PPGM) scenarios

	76	77	78	79	80	81	82
(a) BUMED identify and collect the established Navy and civilian occupational (industrial/commercial) standards of health	X		X				
(b) BUMED publish the standards			X				
(c) BUMED maintain the publication current (annual verification)				X	X	X	X
(a) BUMED collect from the various sources of doctrine publications the applicable operational (air, surface, subsurface, and land) health hazards	X		X				
(b) BUMED publish a single hazard compendium			X				
(c) BUMED validate the compendium annually				X	X	X	X
(d) BUMED evaluate the programmed geographic operational (PPGM) scenarios	X		X				

NAVY HEALTH CARE REVIEW COMMITTEE ARCHITECTURAL PLAN
OBJECTIVE STATEMENT #4

		FISCAL YEAR											
AREA OF CONCERN a. (Cont.)		76	77	78	79	80	81	82					
(e) BUMED identify the scenario hazards in the area of climate, terrain, weapons effects and physical conditioning													
		X	X										

NAVY HEALTH CARE REVIEW COMMITTEE ARCHITECTURAL PLAN
OBJECTIVE STATEMENT #4

NAVY HEALTH CARE REVIEW COMMITTEE

FISCAL YEAR

AREA OF CONCERN

b. RISK NEUTRALIZATION

- BUMED develop general milestones to neutralize evaluated risks in the areas of

(1) disease agent control

(2) environmental modification

(3) occupational hazard control and counter action

(4) personnel protective measures

(5) military operational hazard identification assessment, and counter action

	76	77	78	79	80	81	82
	X		X				
(1) disease agent control	X	X					
(2) environmental modification	X	X					
(3) occupational hazard control and counter action	X	X					
(4) personnel protective measures	X	X					
(5) military operational hazard identification assessment, and counter action	X		X				

NAVY HEALTH CARE REVIEW COMMITTEE ARCHITECTURAL PLAN
OBJECTIVE STATEMENT #4

AREA OF CONCERN	FISCAL YEAR											
	76	77	78	79	80	81	82					
c. EFFECTIVE COMMAND APPLICATION												
(1) Milestone Evaluation												
(a) BUMED monitor program milestones annually to ascertain if completed on time support received accomplished within resources			X	X								
(b) BUMED provide POM input		X	X	X	X	X	X					
(2) Program Evaluation												
(a) BUMED annually analyze disease incident reports and casualty reports of health caused mission abortions against projected risks			X	X	X	X	X					
(b) Operational Commanders incorporate evaluation results into operational doctrine			X	X	X	X	X					
(c) BUMED update MIS data base			X	X	X	X	X					

I-320

MEDICAL DEPARTMENT PREVENTIVE MEDICINE
CNO OBJECTIVE STATEMENT, AREAS OF CONCERN
STANDARDS AND ACTION PLANS

4. "Chief, Bureau of Medicine and Surgery increase the emphasis on the preventive and environmental medicine component of Navy health care support by developing an effective capability for the timely identification and evaluation of health risks in order to provide the line organization with the capabilities to minimize the effects of health risks to Navy and Marine Corps personnel."

a. AREA OF CONCERN - IDENTIFICATION OF HEALTH RISKS
TO PERSONNEL

(1) Disease and Injury (epidemiology) Health Risks

STANDARD

Disease/injury incidence profile (worldwide baseline.)

ACTION PLAN

(a) BUMED develop a worldwide baseline disease/injury incidence profile.

(b) BUMED maintain the profile current.

(2) Physical, Chemical, and Biological (Environmental) Health Risks

STANDARD

Established Navy and civilian environmental standards of health.

ACTION PLAN

(a) BUMED identify and collect the established Navy and civilian environmental standards of health.

(b) Publish the standards.

(c) Maintain the publication current.

- (3) Physical, Chemical, and Biological (occupational)
Health Risks

STANDARD

Established Navy and civilian occupational
(industrial/commercial) standards of health.

ACTION PLAN

- (a) BUMED identify and collect the established
Navy and civilian occupational (industrial/
commercial) standards of health.
 - (b) Publish the standards.
 - (c) Maintain the publication current.
- (4) Navy/Marine Corps Operational Health Risks
(Air/Surface/Subsurface/Land)

STANDARD

Accepted level of military operational hazards
as promulgated in doctrines.

ACTION PLAN

- (a) BUMED collect from the various sources of
doctrine publications the applicable oper-
ational (air, surface, subsurface and land)
health hazards.
- (b) Publish a single hazard compendium.
- (c) BUMED validate compendium annually.
- (d) BUMED evaluate the programmed geographic
operational scenarios.
- (e) Identify the scenario hazards in the area

of climate, terrain, weapon effects, and physical conditioning.

b. AREA OF CONCERN - RISK NEUTRALIZATION

Establish Risk Neutralizing Program

- Generate a risk data base
- Analyze the data
- Develop risk neutralizing milestones.

STANDARD

Generate program milestones.

ACTION PLAN

BUMED develop general milestones to neutralize the evaluated risk in the area of:

- (1) Disease agent control.
- (2) Environmental modification.
- (3) Occupational hazard control and counter action.
- (4) Personnel protective measures.
- (5) Military operational hazard identification, assessment, and counter action.

c. AREA OF CONCERN - EFFECTIVE COMMAND APPLICATIONS

Neutralizing Program Implementation

STANDARD

Program milestone evaluation.

ACTION PLAN

- (a) BUMED monitor program milestones to ascertain if:

- Completed on time
- Support received
- Accomplished within resources.

(b) BUMED display for POM development the identification of resources required, the proposed alternative for the correction of shortfalls, and the impacts as appropriate for POM Year + 4.

(2) Program Evaluation

STANDARD

Published doctrines/policies of relative degrees of operational hazards.

ACTION PLAN

- (a) BUMED analyze disease incident reports and casualty reports of health caused mission abortions against projected risks.
- (b) Operational commanders incorporate evaluation results into operational doctrine.
- (c) BUMED update MIS data base.

NAVY HEALTH CARE REVIEW COMMITTEE
SUMMARY OF MAJOR RECOMMENDATIONS

FISCAL YEAR

B. MAJOR RECOMMENDATIONS

1. SGN/CHBUMED initiate and maintain frequent communications with CMC in order to ensure that both the quantity and quality of medical department personnel to support FMF health care requirements, in both peace and war, be met or at least be given the same priority and consideration as Navy requirements.

2. CNO (OP-090) review Navy Medical Support Program Planning in the following three areas:

- Sponsorship assignments for the Navy Health Care Support Program; develop appropriate changes for implementation prior to the FY 79 CPAM/POM cycle.
- Clear, timely communication lines to facilitate BUMED participation in FY 78 CPAM/POM process.
- FYDP Program 8 restructure review to ensure compliance with OSD guidance contained in DPPG and PCD's.

	76	77	78	79	80	81	82
1. SGN/CHBUMED initiate and maintain frequent communications with CMC in order to ensure that both the quantity and quality of medical department personnel to support FMF health care requirements, in both peace and war, be met or at least be given the same priority and consideration as Navy requirements.					/		
2. CNO (OP-090) review Navy Medical Support Program Planning in the following three areas:					/		
- Sponsorship assignments for the Navy Health Care Support Program; develop appropriate changes for implementation prior to the FY 79 CPAM/POM cycle.	X				/		
- Clear, timely communication lines to facilitate BUMED participation in FY 78 CPAM/POM process.	X	X			/		
- FYDP Program 8 restructure review to ensure compliance with OSD guidance contained in DPPG and PCD's.	X	X			/		

FISCAL YEAR

3. Classified recommendation relative to the support of Amphibious Task Force Landing is contained in Volume III, Section II of this report.

I-326

NAVY HEALTH CARE REVIEW COMMITTEE
SUMMARY OF RECOMMENDATIONS

FISCAL YEAR

C. RECOMMENDATIONS

1. CHBUMED formulate more explicit criteria and guidelines whereby NHCS/civilian inter-relationships, objectives, functions, and expected benefits are clearly delineated and evaluated.
2. CHBUMED use the definitions of health care categories identified by the NHCRC to provide a commonly understood doctrinal frame of reference.
3. CNO/CMC designate CHBUMED as the single source of Navy and Marine Corps health care population data for use in support of any inter-service/OSD sponsored TRI-Service population information collection effort.
4. SGN/CHBUMED adopt the NHCRC definition of "Navy Health Care Support Requirements" to the greatest extent possible as the basis upon which to evaluate and appropriately balance the orientations, skills, and capabilities of Navy Medical Department personnel.

	76	77	78	79	80	81	82
1.							
2.	X	X	X				
3.	X	X					
4.	X	X					

(Interim)

NAVY HEALTH CARE REVIEW COMMITTEE
SUMMARY OF RECOMMENDATIONS

FISCAL YEAR

C. RECOMMENDATIONS (Continued)

5. CHBUMED develop more meaningful and effective measures of medical workload to incorporate some indication of relative intensity and/or complexity of direct patient care provided in terms of injury, illness and wound care, as well as the work performed in dealing with the remaining functions of health care support identified as preventive medicine, health care planning, and health care logistics.

6. CNO, CMC, and SGN direct a conjoint in-depth staff assessment of information pertaining to:

a. the evolution of further centralized health care management and consolidation

b. the implications on the Navy Health Care System resulting from National Health Insurance legislation.

	76	77	78	79	80	81	82
		X	X				
	X	X (interim)	X				
	X	X (interim)	X				

Glossary of Abbreviations

AAFD - American Academy of Family Practice
AAMC - Association of American Medical Colleges
AANA - American Association of Nurse Anesthetists
AAOO - American Academy of Ophthalmology and Otology
AAP - American Academy of Pediatrics
ABFC - Advanced Base Functional Component
ABMS - American Board of Medical Specialties
ACC - American College of Cardiology
AcDu - Active Duty
ACDUTRA - Activity Duty for Military Training
ACMC - Assistant Commandant of the Marine Corps
ACP - American College of Physicians
ACR - American College of Radiology
ACS - American College of Surgeons
A/D - Active Duty
ADA - American Dental Association
ADCON - Administrative Control
ADDU - Additional Duty
ADM - Admission
ADP - Automatic Data Processing
ADPL - Average Daily Patient Load
AFEB - Armed Forces Epidemiological Board
AFHPSP - Armed Forces Health Professions Scholarship Program
AH - Auxiliary Ship Hospital

AHA - American Hospital Association
 AIP - Annual Implementation Plan
 AMA - American Medical Association
 AMAL - Authorized Medical Allowance List
 AMES - Aero Medical Evaluation System
 AMS - Fleet Medical/Dental Support Ship
 AMSA - American Medical Student Association
 ANA - American Nurses Association
 AOA - American Osteopathic Association
 AOA - Amphibious Objective Area
 ARC - American Red Cross
 ASA - American Society of Anesthesiologists
 ASCP - American Society of Clinical Pathology
 ASD (H&E) - Assistant Secretary of Defense, Health and
 Environment
 ASD (I&L) - Assistant Secretary of Defense, Installation
 and Logistics
 ASN (M&RA) - Assistant Secretary of the Navy for Manpower
 & Reserve Affairs
 ASD (PA&E) - Assistant Secretary of Defense, Program
 Analysis and Evaluation
 ASMRO - Armed Services Medical Regulating Office
 ASOC - Area Senior Operational Commanders
 ATF - Amphibious Task Force
 ATG - Amphibious Task Group
 ATU - Amphibious Task Unit
 AVMED - Aviation Medicine
 BAS - Battalion Aid Stations

BEC - Beneficiary Employees Compensation
BUMED - Bureau of Medicine and Surgery
BUMPPG - BUMED Program Planning Guidance
BUPERS - Bureau of Personnel
CAS Rates - Casualty Rates
CECS - Casualty Evacuation Control Ship
CDC - Center for Disease Control
CHAMPUS - Civilian Health and Medical Program of the
Uniformed Services
CHBUMED - Chief Bureau of Medicine and Surgery
CHBUPERS - Chief of Naval Personnel
CHNAVPERS - Chief of Naval Personnel
CHE - Civilian Health Care Support Equivalent
CINCLANTFLT - Commander in Chief Atlantic Fleet
CINC - Commander-in-Chief
CMC - Commandant of the Marine Corps
CNET - Chief Naval Education and Training
CNO - Chief of Naval Operations
CNRC - Chief Navy Recruiting Command
CO - Commanding Officer
COMNAVFACENGCOM - Commander Naval Facilities Engineering
Command
COMNAVSAFECEN - Commander Naval Safety Center
COMNAVSURPAC - Commander Naval Surface Forces Pacific
COMMRDC - Commander Naval Medical Research and Development
Command

CONUS - Continental United States
CPAM - CNO Program Analysis Memorandum
CPPG - CNO Program Planning Guidance
CRTS - Casualty Receiving and Treatment Ship
CSS - Combat Service Support
CWU - Composite Work Unit
DASC - Direct Air Support Center
DCNO - Deputy Chief of Naval Operations
DCP - Development Concept Paper
DEP - Dependents
DISP - Dispersion
DMMB - Defense Medical Material Board
DMSO - Director Major Staff Office
DNBI - Disease and Non-Battle Injury
DNET - Director Naval Education and Training
DNPP - Director of Navy Program Planning
DOD - Department of Defense
DONPIC - Department of Navy Program Information Center
DOW - Died of Wounds
DPPG - Defense Program Planning Guidance
E/LS - Emergency/Lifesaving Care
ENT - Ear, Nose and Throat
EOB - Expense Operating Budget
EPA - Environmental Protection Agency
E.R. - Emergency Room

ERC - Enlisted Rating Coordinator
ERP - Enlisted Requirements Plan
E/S - End Strength
E&T - Education and Training
FAC - Facilities
FLTCINC - Fleet Commander-in-Chief
FLTMED - Fleet Medical
FMF - Fleet Marine Force
FMFLANT - Fleet Marine Force Atlantic
FMSS - Field Medical Service School
FSSG - Force Service Support Group
FY - Fiscal Year
FYDP - Five Year Defense Plan
GAO - General Accounting Office
GME - Graduate Medical Education
GMO - General Medical Officer
GNT - General Navy Training
HCA - Health Care Administration
HCS - Health Care Support
HDC - Helicopter Direction Center
HEW - Health, Education and Welfare
HM - Naval Enlisted Hospital Corpsman
HQ - Headquarters
HQMC - Headquarters Marine Corps

HDQTRS - Headquarters
H&S - Headquarters and Service
HSA - Health Systems Agencies
HSETC - Health Sciences Education and Training Command
HSP - Health Systems Plan
I.D. - Independent Duty
IG - Inspector General
Inf.Bn.Med.Plt. - Infantry Battalion Medical Platoon
INSGEN - Inspector General
ISO - International Standards Organization
ITRO - Interservice Training Review Organization
JAG - Judge Advocate General
JAMA - Journal of the American Medical Association
JAMRO - Joint Area Medical Regulating Office
JCAH - Joint Commission for Accreditation of Hospitals
JCS - Joint Chiefs of Staff
KIA - Killed in Action
LANTFLT - Atlantic Fleet
LF - Landing Force
LKA - Amphibious Cargo Ship
LPD - Amphibious Transport, Dock
LSA - Logistics Support Area
MAB - Marine Amphibious Brigade
MAF - Marine Amphibious Force
MAG - Marine Air Group

MAGTF - Marine Air-Ground Task Force
MARP - Manpower Requirements Plan
MAU - Marine Amphibious Unit
MAW - Marine Air Wing
MED - Medical
MCCC - Medical Control and Coordination Center
Med.Bn. - Medical Battalion
MEDCON - Medical Contingency
MEDEVAC - Medical Evacuation
MC - Medical Corps
MCNT - Military Construction
MILCON - Military Construction
MIS - Management Information System
MMROP - Marine Corps Mid-Range Objectives Plan
MO - Medical Officer
MOSP - Medical and Osteopathic Scholarship Program
MPA - Manpower Authorization
MPN - Military Pay Navy
MRA - Medical Regulatory Agency
MRALO - Medical Regulatory Agency Liaison Office
MRO - Medical Research Officer
MSC - Military Sealift Command
MSC - Medical Service Corps
MSCC - Medical Support Coordination Center
M/Y - Man Years
MYA - Man Year Average

NADEC - Navy Decision Coordinator
NAVCOMPT - Navy Comptroller
NAVFAC - Navy Facilities Command
NAVMAT - Navy Material Command
NAVREGMEDCENS - Naval Regional Medical Centers
NBC - Nuclear, Biological, Chemical
NBME - National Board of Medical Examiners
NDO - Naval Denter Officer
NDPC - Navy Development Concept Paper
NDRF - National Defense Reserve Fleet
NDT - Naval Dental Technician
NEC - Navy Enlisted Classification
NEDEP - Navy Enlisted Dietetic Educational Program
NENEP - Navy Enlisted Nursing Education Program
NFPA - National Fire Protection Association
NHCRC - Navy Health Care Review Committee
NHCS - Navy Health Care System
NDO - Navy Dental Officer
NHE - Navy Health Care Support Equivalent
NHI - National Health Insurance
NIRMP - National Intern and Residents Matching Plan
NITRAS - Navy Integrated Training Resources Administration
System
NMA - National Medical Association
NMCBs - Navy Mobile Construction Battalions

NMDSC - Naval Medical Data Services Center
NMO - Naval Medical Officer
NMRDC - Navy Medical Research and Development Command
NMSCO - Naval Medical Service Corps Officer
NNO - Naval Nurse Officer
NOBC - Navy Officer Billet Classification
NRDC - Navy Regional Dental Center
NRMC - Navy Regional Medical Center
OB-GYN - Obstetrical/Gynecology
ODCR - Officer Distribution Control Report
OF - Operating Forces
OMB - Office of Management and Budget
O&MN - Operational and Maintenance Navy
ONR - Office of Naval Research
OPCON - Operational Control
OPN - Operations Navy
OPNAV - Office of Chief of Naval Operations
OPTAR - Operating Target
OR - Operating Room
ORI - Operational Readiness Inspection
ORP - Officer Requirement Plan
OSD - Office of the Secretary of Defense
OSD(DDR&E) - Office, Secretary of Defense, Director
Defense Research and Evaluation
OSHA - Occupational Safety and Health Act

PA - Physician's Assistant
PACFLT - Pacific Fleet
PBD - Program Budget Decision
PCD - Program Change Decision
PCS - Permanent Change of Station
PCS - Primary Control Ship
PERS - Personnel
PFT - Physical Fitness Test
PHS - Public Health Service
POA&M - Plan of Action and Milestones
POM - Program Objectives Memorandum
POW - Prisoner of War
PPBS - Program Planning Budget System
PPG - Program Planning Guidance
PPGM - Program Planning Guidance Memorandum
PWRMR - Prepositioned War Reserve Material Requirements
PWRMS - Prepositioned War Reserve Material Stock
PWRS - Prepositioned War Reserve Supplies
RAD - Reserve Allocation Display
R&D - Research and Development
RDT&E - Research Development Test and Evaluation
RPN - Reserve Pay Navy
SASSY - Supported Activities Supply System
SEASIA - Southeast Asia
SECDEF - Secretary of Defense

SECNAV - Secretary of the Navy
SGN - Surgeon General Navy
SHCC - Statewide Health Coordinating Councils
SHIPALT - Ship Alteration
SHOROCS - Shore Required Operational Capability Statement
SHORSTAMPS - Shore Requirement Standards and Manpower
Planning Systems
SMD - Ship Manning Document
SMLS - Seaborne Mobile Logistics System
SMSP - Senior Medical Student Program
SQMD - Squadron Manning Document
STAFFTAR - Staff Target
STR - Strength
SUBLANT - Submarine Atlantic
SUBMED - Submarine Medicine
SVS - Service
TAD - Temporary Additional Duty
T/O - Table of Organization
TOA - Total Obligation Authority
TOE - Marine Corps Table of Equipment
TRIMIS - Tri-Service Management Information System
TRP - Training Review Panel
TYCOM - Type Commander
UIC - Unit Identification Code
URL - Unrestricted Line
USAF - United States Air Force

USC - United States Code

USCINCEUR - United States Commander-in-Chief Europe

USMC - United States Marine Corps

USUHS - Uniformed Services University of the Health Services

VCNO - Vice Chief of Naval Operations

VA - Veterans Administration

VH - Navy Helicopter Squadron

VIP - Variable Incentive Pay

VMGR - Marine Corps Refueling Reconnaissance Squadron

VSTOL - Vertical, Short Takeoff and Landing

WIA - Wounded in Action

